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ABSTRACT

This report describes the first year (Phase I) of the 3-year evaluation of the Child and Family Mental Health (CFMH) Project. Phase I was designed to provide a descriptive analysis of the CFMH Project in terms of the number and characteristics of recipients of the services, the nature and extent of the specific primary prevention approaches used, the community and Head Start context within which the community CFMH Project operates, and the implementation process at each program. Following an introductory overview (Chapter 1) of the evaluation's phases and objectives, Chapter II describes the methodology of the pilot study which provided exploratory data on the evaluation instruments intended for use in Phases II and III. The design of the pilot study, as well as the instruments and the site selection and sampling methods used in the study are also described. The descriptive analysis of the nine experimental and five control sites involved in the pilot study is given in Chapter III. Each site is described in terms of the demographic characteristics of the community and its Head Start program, as well as the development, structure, administration, coordination, major goals, objectives, activities, support system/resources, and evaluation of the CFMH Project. Finally, results of a psychometric analysis of the 15 center profiles obtained from site visits is included in Chapter IV. (Author/MP)

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EVALUATION OF THE
CHILD AND FAMILY MENTAL HEALTH PROJECT
PHASE I

CONTRACT NO. HHS 105-77-1057

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CHAPTER I

INTRODUCTION

The evaluation of the CFMH Project involves a three-year study which includes process, impact and in-depth components. The process evaluation is designed to provide a descriptive analysis of the CFMH Project. Critical information will be collected relative to the number and characteristics of recipients of the services, the nature and extent of the specific primary prevention approaches used, the community and Head Start context within which the CFMH Project operates, and the implementation process at each program. Its primary objectives then, are:

1. To describe the 28 programs, particularly with regard to CFMH Projects at experimental sites and primary prevention efforts generally at control sites according to the guidance questions in the RFP.

2. To provide the companion program data necessary to identify the characteristics associated with successful CFMH strategies.

3. To provide a basis for examining experimental and control group equivalence on selected program variables which might affect implementation of a primary prevention project.

4. To provide a basis for determining experimental control group differences on operating variables which characterize or are indicative of the type and levels of primary preventive services offered by each.

The impact or outcome phase of the evaluation is designed to determine the program effects or the extent and type of changes occuring as a result of the experimental treatment of the Child and Family Mental Health Project. The primary goal of the evaluation is to determine the impact of the primary prevention services and activities on Head Start staff, parents and children, in comparison to a control group. Thus, the impact phase of the evaluation may be conceptualized as involving dichotomous, but, interdependent phases, intermediate and outcome. The intermediate level of analysis of the impact phase aims at determining the effect of the intervention or treatment on the Head Start staff, parents and classroom environment, which theoretically, mediate the changes in the children, since the CFMH Project does not intervene directly with the children. These intermediate effects then provide the necessary link between the intervention or treatment at the center and the impact on the children. The ultimate outcome variables, then, involved the effectiveness of the indirect mental health service approach

of the CFMH Project in promoting "mental wellness" in Head Start children.

The in-depth evaluation will provide more intensive and comprehensive data about the program and the nature of the changes it induces in those programs in which CFMH strategies achieve the greatest success or demonstrate the greatest potential. Thus, the in-depth study will collect more detailed information on four (2 CR and 2 MHW) sites selected for their use of strategies and interventions which appear promising in terms of effectiveness, replicability, and transportability. The design also includes measurement at the four control sites matched to those programs. The primary purpose of the more intensive investigation is to document exactly how guidelines are translated into practices in these programs and how various participants are affected.

The first year or Phase I of the three-year evaluation of the Child and Family Mental Health Project was designed as a planning and development effort. Accordingly, the principal tasks were:

1. The development of a detailed evaluation design and implementation plan for the three phases of the evaluation;

2. The development of the instruments and procedures to be utilized in the process evaluation in Phase II and Phase III of the evaluation;

3. To conduct a pilot study of the process evaluation;

4. The selection and development of a battery of instruments to be utilized in the impact and in-depth phases of the evaluation;

5. The development of an impact design and sampling strategy.

The second year of the evaluation includes a process evaluation of the 14 CFMH Projects and 14 comparison Head Start sites. Also, pilot testing for the impact evaluation will be conducted at four experimental sites with four control sites. Finally, there will be pilot in-depth study of two CFMH sites and two comparison sites.

The third year will include a replication of the process study, as well as full-scale implementation of the impact and in-depth components. Table 1.1 outlines the three-year scope of work and time line. An overview of the Phase I activities and an outline of the Phase I report are described in the succeeding pages.

Overview of Phase I Activities

Implementation of Phase I of the evaluation proceeded according to contract specifications outlined in the scope of work. The initial task, following the selection and hiring of staff, was to conduct a

systematic orientation for staff to the evaluation contract, primary prevention theory and practice, the concept of "mental wellness", the Child and Family Mental Health Project, along with Head Start and its mental health approach. Thus, the staff reviewed key documents such as the original technical proposal submitted by The Urban Institute for Human Services, Inc. to ACYF in 1977, the scope of work and the modification, etc. Formal and informal discussions were held with staff to discuss issues related to these documents. Also, as part of the initial orientation of the evaluation staff, and consistent with Task #2 of the evaluation contract, several staff members from the Urban Institute for Human Services, Inc. accompanied a Field Specialist to a CFMH Project in Reno, Nevada in November, 1978, and participated in a SAVI visit to San Jose, California in December, 1978. These visits served to provide a greater understanding of Head Start, its mental health component, the functioning of a CFMH Project and implementation issues associated with the delivery of mental health services.

Concomitant with the staff orientation, The Urban Institute staff initiated an extensive review of the literature in the areas of primary prevention, evaluation of early childhood intervention programs, indirect services, and child behavioral measurement. Relevant bibliographies and references were developed to assist in the conceptualization of variables related to the measurement of social competency and mental wellness and to identify the best available instruments relevant to the objectives of the process, impact, and in-depth phases of the evaluation.

The final stage in the preliminary planning of the evaluation contract was a series of "brainstorming" meetings between the ACYF staff and the principals of The Urban Institute for Human Services, Inc., which were held between October and December 1978. The purpose of these meetings was to conduct a systematic review of the scope of work, and, to launch the conceptualization, planning, and implementation of the evaluation contract. In addition, these meetings served to identify and select the six-member advisory panel charged with the responsibility of reviewing the evaluation contract. The more specific plans and implementation for the evaluation were initiated in October of 1978, beginning with the collection of proposals and other program documents from ACYF and from the T&TA Contractor. Certain of these documents such as initial and continuation proposals, grantee plan of action, reports by the training and technical assistance contractors, etc., were utilized to provide descriptive information about the CFMH Projects and the control groups. Other data or information such as the initial RFP for the CFMH Project, Head Start Performance Standards, SAVI, and Management Information System provided information about factual guidelines for the CFMH Projects, standards for the Head Start mental health component and secondary data sources for the evaluation. As the data accumulated from the request for documents, reports, etc. and the review of the literature, more concrete plans were made for task schedules deliverable dates, scope of work modifications, and long-range research strategies. To further facilitate preparation of the final evaluation design and implementation

plan, the staff developed internal documents in the key area of preventive mental health, research and evaluation design, process and outcome phase, and preliminary summary of Child and Family Mental Health Project activities. The documents then stimulated discussion of the sections of the evaluation plan which were forwarded to the advisory panel members in December, 1978 prior to the first meeting of the panel. The first drafts were subsequently forwarded to ACYF in late January and February, respectively. The revised Evaluation Design and Implementation Plan for the Child and Family Mental Health Project describes in detail the procedures and methodology for the three phases of the evaluation.

While planning and developmental work was in progress during January of 1979, ACYF regional offices and the 28 programs were contacted formally and introduced to the evaluation goals and its methodology. Following the introductory contacts, additional information was requested from each program for use in choosing the sites to be included in the pilot test of process measures. This selection process was completed in late March and site visits (Task 8) were conducted in April and May. Concurrent with the collection of Phase I pilot data, final recommendations for impact and in-depth instruments were being developed for submission to ACYF (Tasks 5, 7 and 9). The document Review and Recommendations for the Impact and In-Depth Instruments describes the rationale, selection procedures, and the specific instruments to be utilized in the impact and in-depth studies in Phase II and Phase III of the evaluation.

Following the pilot study of the process evaluation, the process instruments and procedures to be used in Phase II and Phase III of the evaluation were revised and are included in the OMB Clearance Request for the Process Measures of the CFMH Evaluation.

The final activities scheduled to occur in Phase I of the evaluation contract are the development of the impact design and sampling strategy and planning for Phase II of the evaluation. The proposal for the impact design and sampling strategy is presently being finalized. In reference to planning for Phase II of the evaluation, during the months of August and September 1979, planning data has been collected from all 28 experimental and control sites, process samples were drawn, and site development activities were initiated. Additionally, field plans are being finalized and the staff will be selected and trained during this period.

Table 1.1

Time Line for Year 1 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 1 - Select advisory panel members	--o												
Task 2 - Participate in SAVI & T & TA site visits	------	--o	o										
Task 3,- Compile program documents, secondary 4 sources for use in developing & 5 evaluation plan & instruments	--o												
Task 3 - Develop evaluation plan; submit to ACYF for approval	--o	o	o	----o									
Task 1 - Advisory panel meeting (#1) to review evaluation plan	------	------	------	----o									
Task 3 - Submit revised evaluation	------	------	------	----o	------	------	----o						
Task 4 - Develop process measures & submit to (part 1) ACYF for approval	------	--o	o	----o									
Task 5 - Develop/select impact & in-depth measures; recommend to ACYF	------	--o	o	------	------	------	------	----o					
*Task 7 - Submit approved impact & in-depth (part 2) measures to OMB	------	------	------	------	----o	------	------	------	------	------	----o		

Table 1.1 (continued)

Time line for Year 1 of the Evaluation Contract

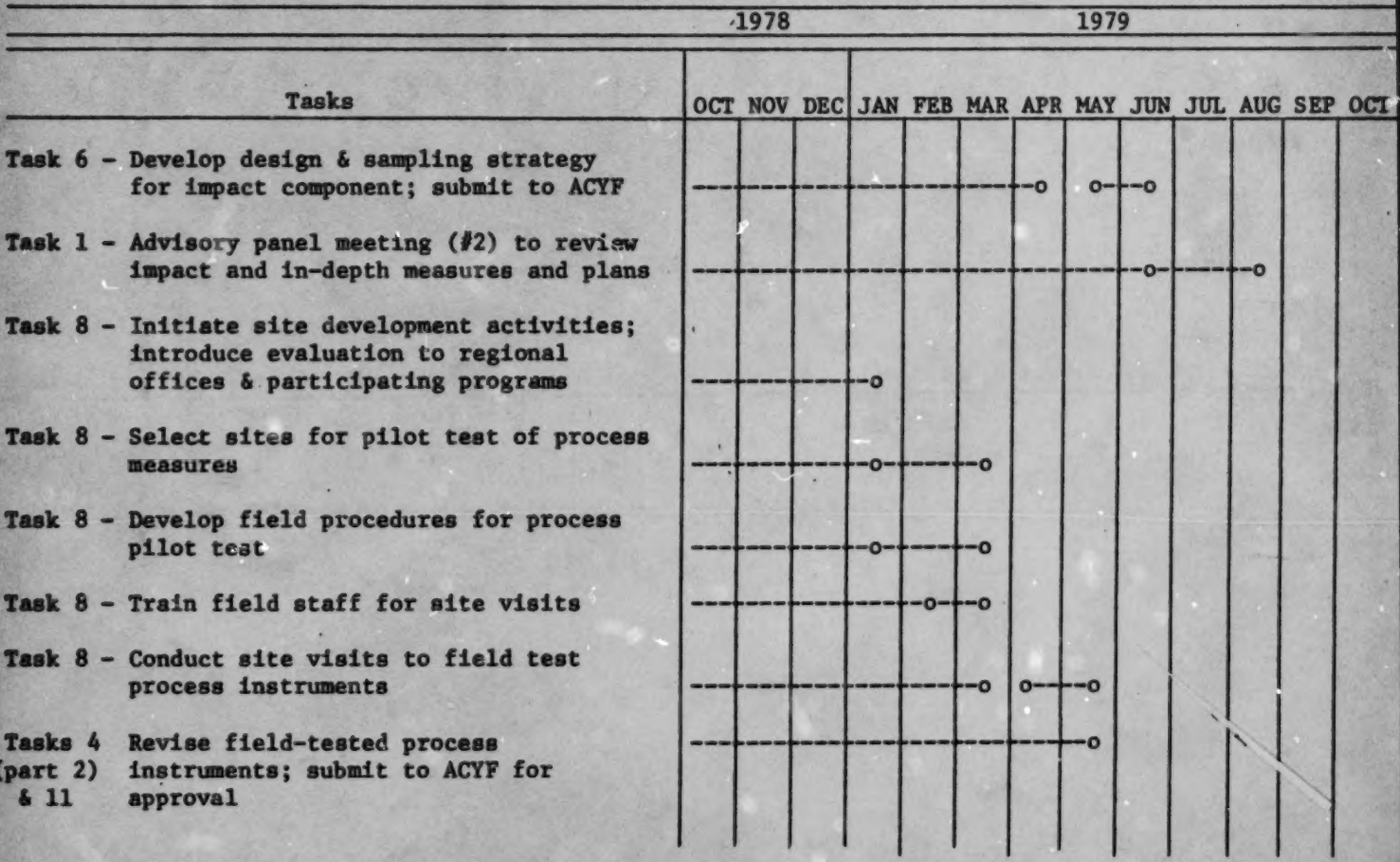
1978
1979
Tasks
OCT NOV DEC JAN FEB MAR APR MAY JUN JUL AUG SEP OCT
Task 6 - Develop design & sampling strategy for impact component; submit to ACYF
Task 1 - Advisory panel meeting (#2) to review impact and in-depth measures and plans
Task 8 - Initiate site development activities; introduce evaluation to regional offices & participating programs
Task 8 - Select sites for pilot test of process measures
Task 8 - Develop field procedures for process pilot test
Task 8 - Train field staff for site visits
Task 8 - Conduct site visits to field test process instruments
Tasks 4 (part 2) & 11 Revise field-tested process instruments; submit to ACYF for approval

Table 1.1 (continued)

Time line for Year 1 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 7 - Submit ACYF-approved process instruments (part 1) to OMB					o				o				
Task 8 - Analyze pilot data									o	o			
Task 8 & 9 - Draft Phase I report (including in-depth design), executive summary & non-technical report; submit to ACYF											o	o	
Task 8 - Advisory panel meeting (#3) to review Phase I report			o								o	o	
Task 8 - Final Phase I report, executive summary and non-technical report due to ACYF											o	o	
Task 10 & 11 - Collect planning data for Phase II (rosters, new proposals, etc.)										o			
Task 10 & 11 - Initiate Phase II contacts with Head Start programs, regional offices										o	o		
Task 10 & 11 - Develop Phase II field plans and field materials											o	o	

Table 1.1 (continued)

Time line for Year 1 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 10-Select Phase II samples & 11	----	----	----	----	----	----	----	----	----	----	----	o	
											o	o	
Task 10-Recruit, select process instruments & site monitors	----	----	----	----	----	----	----	----	----	----	o	o	
Task 16, Hold planning meetings with Head 10 & 11-Start staff & policy boards	----	----	----	----	----	----	----	----	----	----	----	o	
Task 10-Train process interviewers & site monitors	----	----	----	----	----	----	----	----	----	----	----	o	

*OMB Submission will be necessary only if unpublished impact and in-depth measures are recommended and approved by ACYF

Table 1.1 (continued)

Time line for Year 2 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 11 - Conduct site visits to collect fall process data	--o												
Task 11 - Analyze fall process data	-----	--o	o										
Task 10 - Collect interim process data	----------		--o	o	o								
Task 11 - Draft report on fall data collection; submit to ACYF	-----	--o											
Task 1 - Advisory panel meeting (#4) to review report on fall data collection	----------			--o									
Task 10 - Select impact and in-depth pilot sites using fall data	----------		--o										
Task 10 - Recruit, select impact & in-depth observers; fill any vacant process interviewer, site monitor slots	----------			--o	o								
Task 10 - Train impact & in-depth observers; re-train process interviewers	----------			----	--o								
Tasks 10 & 11 - Conduct site visits, collect spring process data; field test impact and in-depth measures	----------			----	----	--o	o						

Table 1.1 (continued)

Time line for Year 2 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 10 - Collect end of year process data	----	----	----	----	----	----	----	-o					
Tasks 10 & 11 - Analyze interim spring, end of year process data; analyze pilot impact & in-depth data	----	----	----	----	----	----	----	-o	o				
Task 10 - Draft report on pilot test of impact & in-depth measures; submit to ACYF	----	----	----	----	----	----	----	----	----	-o	o		
Task 11 - Conduct site visits to collect fall process data	--o												
Task 11 - Analyze fall process data	----	-o	o										
Task 10 - Collect interim process data	----	----	-o	o	o								
Task 11 - Draft report on fall data collection; submit to ACYF	----	-o	o										
Task 1 - Advisory panel meeting (#4) to review report on fall data collection	----	----	----	-o									
Task 10 - Select impact and in-depth pilot sites using fall data	----	----	-o										

Table 1.1 (continued)

Time line for Year 2 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 10 - Recruit, select impact & in-depth observers; fill any vacant process interviewer, site monitor slots	----	----	----	o	o								
Task 10 - Train impact & in-depth observers; re-train process interviewers	----	----	----	----	o								
Tasks 10 & 11 - Conduct site visits, collect spring process data; field test impact and in-depth measures	----	----	----	----	----	o	o						
Task 10 - Collect end of year process data	----	----	----	----	----	----	----	o	o				
Tasks 10 & 11 - Analyze interim spring, end of year process data; analyze pilot impact & in-depth data	----	----	----	----	----	----	----	o	o				
Task 10 - Draft report on pilot test of impact & in-depth measures; submit to ACYF	----	----	----	----	----	----	----	----	----	o	o		
Task 11 - Draft report on Phase II process evaluation, submit to ACYF	----	----	----	----	----	----	----	----	----	o	o		

Table 1.1 (continued)

Time line for Year 2 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Tasks 1 & 10 - Advisory panel meeting (#5) to try out clinical assessment procedures, recommend in-depth sites for Phase III	----	----	----	----	----	----	----	----	o				
Task 1 - Advisory panel meeting (#6) to review pilot and 2nd round reports	----	----	----	----	----	----	----	----	----	----	o		
Tasks 10 & 11 - Final Phase II report, executive non-technical report due to ACYF	----	----	----	----	----	----	----	----	----	----	----	o	
Task 12 - Collect planning data for Phase III	----	----	----	----	----	----	----	----	----	----	o		
Task 12 - Initiate Phase III contacts with Head Start programs, regional offices	----	----	----	----	----	----	----	----	----	----	o	o	
Task 12 - Replace any field staff positions	----	----	----	----	----	----	----	----	----	----	o	o	
Task 12 - Retrain any field staff replacements	----	----	----	----	----	----	----	----	----	----	----	o	
Task 12 - Select final in-depth sites	----	----	----	----	----	----	----	----	----	----	----	o	
Task 12 - Select Phase III samples	----	----	----	----	----	----	----	----	----	----	----	o	

Table 1.1 (continued)

Time line for Year 3 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 12 - Conduct site visits to collect fall process, impact & in-depth data	--o												
Task 12 - Collect interim data	-----	-o	o										
Task 12 - Compile fall & interim data	----------		-o	o									
Task 12 - Advisory panel meeting (#7)	----------			-o									
Task 12 - Conduct site visits to collect spring data.	----------					-o	o						
Task 12 - Fill any vacant field positions	----------			o	o								
Task 12 - Retrain field staff	----------				-o								
Task 12 - Collect end of year process data	----------							-o	o				
Task 12 - Analyze fall, spring, interim, and end of year data	----------							-o	o				
Task 12 - Advisory panel meeting (#8) to perform clinical assessments	----------								-o				
Task 12 - Draft Phase III report; submit to ACYF	----------									-o			

Table 1.1 (continued)

Time line for Year 3 of the Evaluation Contract

Tasks	1978 OCT	NOV	DEC	1979 JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT
Task 1 - Advisory panel meeting (#9) to review Phase III report											o		
Task 12 - Final Phase I report, executive summary, non-technical report due to ACYF												o	

Progress Report by Tasks

As a means of reflecting the progress made on the scope of work during the first year of the evaluation contract, the specific tasks and the progress made on each task will be explicated in this section. In general, the first year of the contract called for the development of plans, the selection and/or development of instruments, and a pilot study of the process evaluation. The specific tasks and progress report by tasks follow.

Task 1: Select a review panel of experts to assist the Contractor in the conduct of the evaluation.

A November 9, 1978 memorandum from Dr. Thomas O. Hilliard to Dr. Steven Martinez contained the names of six experts to serve on the review panel. The experts were judged to have a broad understanding of evaluation, preventive mental health and child development, and specific expertise in one or more of the following areas: observational assessment and measurement, experimental and evaluative design issues, prevention, child development, and mental health. Each expert was judged to be knowledgeable and/or sensitive about minority mental health issues. Subsequently, six panel members consented to serve on the review panel and were accepted by the Project Officer. These included:

Dr. George Albee, a past president of the American Psychological Association, is currently a professor at the University of Vermont. He has been a leader in the preventive mental health movement exemplified in the cogent views presented in his article "Primary Prevention" which appear in Annual Review of Psychology in 1975 and his book, Primary Prevention of Psychopathology. More recently, Dr. Albee served as the Chairman of the Task Force on Prevention of the President's Commission on Mental Illness.

Dr. Carmen Carrillo, a graduate of the University of California at Berkeley, is a clinical psychologist who is currently serving as Director of the Mission Mental Health Center. Dr. Carrillo has extensive direct and indirect (i.e., consultation) experiences with mental health programs serving Spanish-speaking populations. Thus, Dr. Carrillo has expertise in the mental health and psychological issues of Chicano children and families.

Dr. Gloria Powell is a pediatrics psychiatrist at U.C.L.A. School of Medicine. She has conducted cross-cultural research in Africa and the United States on child development. Her interest and publications are in the area of self concept, identity, and intellectual development of black children. In fact, Dr. Powell recently served as an expert witness in the Larry P. vs. Riles court case relative to the long-term effects of Head Start on young children.

Dr. Michael Scriven, formerly professor at the University of California, Berkeley, is currently the Director of the Evaluation Insti-

tute at the University of San Francisco. Dr. Scriven has held numerous responsible positions pertaining to evaluation in academic, research, and practical settings. He is, therefore, quite skilled in both theoretical and methodological aspects of evaluation. In fact, according to his resume, he was responsible for the introduction of the terms "formative" and "summative" evaluation. Finally, Dr. Scriven's expertise in evaluation bias and goal-free evaluation are vital to the development of a creative approach to program evaluation that avoids the pitfalls of previous evaluations of Head Start.

Dr. Jane Stallings is an educational researcher with the Stanford Research Institute, where she has managed and participated in research projects involving Head Start and daycare centers and follow-through programs. The unique area of expertise that Dr. Stallings provides the review panel is experience and skill in the area of observational instrument development and early childhood development.

Dr. Shirley M. Willard is the Director of the Office of Preprimary and Family Education, Michigan Department of Education, Lansing, Michigan. She has had extensive work in child development and preschool education programs including a focus on early childhood social competency. Her service on several relevant State committees and task forces reinforces the panel's experience in explicating the implications of research and evaluative data for policy decisions.

Task 2: Have key staff participate as members of site visit teams to the CFMH Projects, Head Start, and one in-depth validation of a SAVI.

On November 27, 1978, Dr. Phil McGee, Research Scientist, Dr. Laura Head, Research Associate, and Ms. Sheryl Smith, Research Assistant, visited the Head Start Center in Reno, Nevada. The visit was in conjunction with a visit by Dr. Marty Glasser, the Field Specialist from Planning and Human Systems. The evaluation staff members observed the program, and, to a lesser extent, the interaction between Dr. Glasser, the Mental Health Worker (MHW) and the MHW's Supervisor. In addition to making observations, the evaluation staff was able to respond to some of the Head Start staff's concerns about the evaluation.

Dr. Head and Ms. Smith also visited a Head Start Center in San Jose in conjunction with a SAVI site visit team. The visit took place on December 5 and 7, 1978. The evaluation staff observed the interaction of the Consultants with Head Start staff and the procedure by which it is determined whether or not the Center is in compliance with the Head Start Performance Standards.

Task 3: Prepare an evaluation design and implementation plan.

A draft of the Evaluation and Implementation Plan was submitted to the Project Officer on January 31, 1979. Dr. Martinez's written comments on the Evaluation Plan led to a major restructuring of the Plan. At the time of this report's preparation, the Evaluation

Design and Implementation Plan is being revised to include Dr. Martinez's comments as well as the experiences of the first round of site visits.

Task 4: Select the process measures to be used in Phases I and III of the evaluation.

Task 4 was operationalized as the development of process instruments rather than the selection of instruments. Given the fact that each CFMH program designed intervention strategies to serve the needs of its children, teachers, and parents, it was important that process instruments be able to describe the center's program in terms specific enough to replicate the intervention in other settings. Pursuant to the goal of developing a set of instruments capable of providing a detailed description of the programs, instruments were designed as interview schedules for the following respondents:

Head Start Director
Head Start Teachers
Other Head Start Staff
CFMH Provider
Mental Health Provider
Mental Health Coordinator
Mental Health Supervisor
Parents

Experimental and control versions as well as Spring and Fall versions of each document were developed. These instruments were subsequently field-tested and submitted to the Project Officer and OMB for approval.

Task 5: Select the impact assessment and observation instruments to be used in Phases II and III of the evaluation.

The procedure employed in the selection of impact measures and observational instruments began in Phase I of the project and extended into Phase II. The procedures used for selection as well as a recommended set of instruments were presented in draft form for review and approval on September 28, 1979. The document, entitled Review and Recommendations for the Instrument Battery for the Impact and Indepth Phases of the Evaluation, was reviewed by Dr. Martinez. Modifications based upon Dr. Martinez's comments are currently being prepared and the document is expected to be resubmitted early in Phase II.

Task 6: Develop the sampling strategy and experimental design for the impact evaluation.

The development of the design and sampling plan for the impact evaluation was delayed until Phase II after the experience of the first full scale set of site visits for the process evaluation, but before the pilot test of the impact evaluation.

Task 7: Prepare OMB package requesting approval for instruments that fall within OMB's domain.

The OMB Clearance Request for Process Measures was submitted for approval on July 19, 1979. Several modifications were subsequently made in response to Dr. Martinez's review.

Task 8: Conduct a pilot process evaluation of four CFMH Projects.

The pilot study has been completed. The report of its methodology and results of the pilot study comprise a substantial part of the current report.

Task 9: Design an in-depth evaluation.

The Evaluation Design and Implementation Plan contains the design of the in-depth evaluation. This document, spoken of in the report on Task 3, will be complemented by a later report entitled Evaluation of Child and Family Mental Health Project: Design and Sampling Plan.

In general, the first year of the evaluation established the evaluation project as a dynamic rather than static evaluation. Fortunately, the scope of work anticipated the need for such flexibility as pilot studies and modifications based upon these pilot studies built into the design. The implications for the evaluation design and methodology and implications for programs are discussed in Chapter V.

CHAPTER II

PILOT STUDY METHODOLOGY

Since site visits were to represent the first substantive contact between programs and members of the evaluation team, the pilot study was designed with highly exploratory emphasis. Consistent with that emphasis, Phase I data collection was aimed at meeting the following broad objectives: (1) to test the instruments that would be used in the full-scale process evaluation in Phases II and III; and (2) to determine necessary changes in procedures for record-keeping which would facilitate the collection of the information required by the process data base. A description of the research plan used to accomplish these objectives follows.

Pilot Study Design

Task VIII of the contract scope of work called for pilot data to be collected at all 14 experimental sites. This plan was considered desirable because, by the time scheduled for the pilot study, CFMH Projects would have been in operation for close to two years without any systematic data having been compiled. Therefore, the need to sensitize programs to the importance of documenting their efforts and to initiate the documentation process in as many CFMH Projects as possible was particularly compelling. However, since the original plan did not provide for contact with comparison programs, it was altered to allow for as much contact with CFMH programs as was considered feasible, while simultaneously permitting a reasonable pilot test of materials and procedures appropriate to control settings.

OMB regulations permit only nine administrations of instruments which have not been cleared for use, a maximum of nine CFMH programs could be included in the sample. Therefore, the pilot plan called for site visits to be made to nine CFMH programs and five matched controls, which appeared to represent the best compromise between the OMB guidelines, the critical need for information on CFMH operations, and contract specifications which set the number of site visits at 14 for Phase I of the process evaluation.

Site Selection and Sampling

Selection of the nine CFMH sites was based on program model (CR vs MHW), geographic location, and urbanization index. Geographic classification reflected the same groupings of states and HEW regions as were used in the Head Start Transition Study and the Head Start Health Evaluation: Northeast (Regions I, II, III and V), South (Region IV), and West (Regions VII, VIII, IX, and X). The three levels of urbanization (urban rural, and urban/rural) were the same as those established by

ACYF in the process of making the initial experimental and control assignments.

Selection of the control sample was made from those programs whose matched CFMH sites were chosen for the pilot study. Within that set, choices were made to achieve a balance between CR and MHW controls and to minimize travel costs.

Table 2.1 lists the 14 programs chosen for the pilot study and classifies each according to its status on the three major selection variables. Five C sites, three CR controls, four MHW sites, and two matched MHW controls served as the pilot sample.[1] Among the five CR programs selected, three are urban, one rural and one mixed. Two of the five programs are located in the Northeast, two in the West, and one in the South. The three CR control programs, all of them urban, are located in the Northeast, the South and the Southwest.

The MHW sample consisted of one urban/rural program located in the West and three rural programs, one each drawn from the West, Southwest, and South. The two MHW control programs, both of which are classified as rural, are located in the West and in the South.

A comparison of the pilot sample and the full set of programs from which selections were made revealed only one obvious imbalance. Due to the matching rule used in selecting control programs, only urban programs were included in the CR control sample despite the fact that the full group contains two rural and two urban/rural programs. Otherwise, a reasonable degree of diversity was achieved on the three selection variables and the balance in the pilot sample appeared adequate for insuring a valid field test of process instruments.

Within both experimental and control sites, the respondent sample consisted of the following people: The Head Start Director, the staff person responsible for overseeing mental health services, one teacher, and one parent. At experimental sites, the principal CFMH Provider also was included, and in the case of programs employing the MHW model, the Mental Health Supervisor as well. To maximize the study's potential for generating rich and informative responses, parents and teachers were selected on the basis of recommendations made by the Head Start Director.

Pilot Instruments

In developing pilot instruments, items were written to represent fully each major class of variables necessitating information that could not be obtained from available documents. Once an expanded pool of

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[1] A last minute scheduling conflict necessitated a substitution which resulted in the sample containing only two matched pairs of experimental and control CR rather than three.

items had been generated, interview schedules were tailored to each of the roles represented in the sample.[2] This task was accomplished by having three staff (two of whom had not been involved in writing items) judge each question's appropriateness to each type of respondent. The resulting instruments were examined further by a team of four staff (including the principal item writer) in order to reduce the length of required interviewing time to 30-45 minutes per instrument. Items were deleted on the basis of their relative importance and the availability of alternative sources of the requested information.

A fifth staff member reviewed the remaining item pools for relevance to the evaluation's general purpose, for compliance with Task IV of the scope of work, and for completeness relative to the informational framework outlined in Tables 2.2, 2.3, and 2.4. Additional modifications in wording, structure, and length were made subsequently using feedback from ACYF staff.

Through these procedures, ten interview schedules were developed, six for administering at CFMH sites, and four for use at matched control sites. In the following paragraphs, instruments are described according to purpose and areas emphasized. The instruments themselves are available for review in a separate document.[3]

CFMH Provider Interview Schedule. As the best sources of the basic information on how CFMH goals were operationalized, providers are asked to describe services and activities, the levels of service provided, the functions they perform on the project and for Head Start as a whole, as well as the amount of time they devoted to the various activities. In addition, providers serve as the primary source of information on the kinds of changes sought by the project, and the kinds of changes observed among staff, parents and children. Providers also are asked to evaluate the training and support they received, as well as their satisfaction with their roles with the project as a whole.

Mental Health Supervisor Interview Schedule. The Mental Health Supervisor is the chief source of information about the agency which collaborated with the Head Start program on MHW projects and about the type and amount of training and support the agency provided.

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[2] Restrictions placed on the Pilot study by ACYF will prevent the use of questionnaires or any other form of self-administered instruments.

[3] OMB clearance request for the process measures of the CFMH evaluation.

Table 2.1

Classification of Process Evaluation Pilot Sites According to Model, Urbanization and Geographic Area

Model	Urban	Rural	Urban/Rural
COMMUNITY RESOURCE: EXPERIMENTAL	Berkeley, CA (W) Indiana, PA (NE) Tacoma, WA (W)	Live Oak, FL (S)	Bridgeton, NJ (NE)
CONTROL	Decatur, GA (S) Chester, PA (NE) Galveston, TX (SW)		
MENTAL HEALTH WORKER EXPERIMENTAL		Appleton City, MD (W) Laredo, TX (SW) Troy, AL (S)	Reno, NV (W)
CONTROL		Kirkesville, MO (W) Hughesville, MD (NE)	

Notes: The designations for regions are as follows: NE = Northeast, S = South, SW = Southwest, and W = West. One MHW control program could not be classified according to urbanization.

Table 2.2

Guidance Questions for Developing
Process Measures (Source: RFP)

A. Services provided

1. How many children are served?

2. What is the frequency with which services are provided to staff, parents and children, the length of time over which services are provided and the total number of hours of services provided?

3. What services is the mental health worker providing with regard to:

   a. orientation of staff and parents
   b. training of staff and parents
   c. staff consultation and support consultation
   d. counseling parents (crisis intervention)
   e. curricular input

4. What forms of Head Start staff orientation training and consultation are provided by the CFMH staff?

   a. How effective are these services?
   b. What curriculum and training model are used?

5. Are crisis situations such as interpersonal conflicts, children's emotional outbursts, family quarrels, etc. treated promptly? appropriately?

6. How is the value of the services given rated by the Head Start staff, parents and the mental health staff?

7. What services are delivered to parents? obtained for parents? by type of problem, by type of recipient.

8. Are children and adults receiving effective, timely and sufficient preventive services in respect to:

   a. mental health education
   b. follow-up
   c. support-consultation
   d. coordination of services within Head Start
   e. coordination of all professional services

B. Mental Health provider staffs (Model A and Model B):

1. Is the staff called on to do competing jobs?

Table 2.2 (Continued)

2. What is the training and experience of the staff members?

3. What activities do the staff rate as being done well? poorly?

4. What is the mental health staff/child ratio?

5. How were the provider staff recruited and selected?

6. Were the training and supervision perceived as adequate by the staff and the Head Start directors?

7. How does the mental health provider function within the Head Start setting?

8. Is the provider staff satisfied with their jobs? With the CFMH project? With each particular assigned task?

C. Administration

1. What is the basic management information on costs, absenteeism, staff turnover, and so forth?

2. How effective was the training of the CFMH staffs?

3. What training packages are used for training the CFMH staff?

4. Do some centers get disproportionate amounts of services?

5. What were the difficulties in start up?

6. What are the characteristics of the supervisors of Mental Health Workers (Model B)?

7. How is supervision rendered?

8. What are the support systems for the Community Mental Health Resource staff (Model A)? How is the staff supervised? What is the supervision?

D. The Internal characteristics of each CFMH project:

1. What are the major project activities?

2. What is the relative emphasis placed on each activity?

3. How do project activities relate to project objectives?

4. What are the project resources?

5. How is the staff organized in terms of tasks, amount of time worked, and responsibilities?

6. What are the formal and informal patterns of communication within the project?

7. Are there significant or notable differences in the types of problems encountered among projects, within or across programs?

8. Does the project assess itself and if so, how?

E. Characteristics of the Head Start comparison programs:

1. What are the major activities of the programs?

2. What is the relative emphasis placed on each activity?

3. What are the mental health resources available to the program?

4. What mental health services are rendered by the program?

5. What program activities can possibly exert the influence of a preventive mental health program even though they may have been designed for some other purpose?

F. The context in which each CFMH project and Head Start comparison site operates.

1. What are the characteristics of the community?

2. To whom do mental health providers report?

3. Is there any relationship between project "success" and community characteristics?

4. What are the non-traditional mental health resources extant in the community which are potentially available to the projects, to the clientele, etc.? (e.g., pastoral, other spiritual, medical)

5. What are the viable arrangements and agreements which exist between Head Start and other agencies or with professionals at the project locations?

6. Which of the project activities duplicate or overlap existing CFMH services?

Table 2.2 (Continued)

7. What local resources are available and utilized by the Head Start program?

8. Is the Head Start program a part of the community of is it a parallel system to the community?

9. What is the status of Head Start in the community?

Table 2.3

Contextual Variables and Sources of Information:
Community Characteristics and Resources[a]

Dimension/Variable	Source of Information
Context Variables	
I. Community Characteristics	
A. Service area (cities/counties)	CFMH proposal
1. Total land area	COTP Table 9
2. Total urban, rural populations	COTP Table 9
B. Population characteristics	
1. Population by race	COTP Tables 16 & 34; CYF application (Needs Asmt.)
2. Number of children under 5: total, by race	COTP Table 35
3. Number of families with children under 5: total, by race	COTP Table 36
4. Median income	COTP Table 45
5. Number unemployed	COTP Table 45
6. Number families/individuals below poverty level	COTP Table 45; CYF application (Needs Asmt. Sect.)
7. Number single parent families	ACYF application (Needs Assessment Section)
C. Community Resources for Mental Health Services	CFMH Proposals; Resource Directory; MH Coordinatory; Selected Inquiries
1. Number (total, by type)	
2. Characteristics of agencies	
a. Services provided (general, for children)	
b. Eligibility requirements	
c. Fees	
d. Location	

[a]Abbreviations: COTP-Characteristics of the population, US Census and Population Reports

Table 2.4

Contextual Variables and Sources of Information:
Head Start Administration and Organization[a]

Dimension/Variable	Source of Information
II. Head Start Context	
A. Administrative & Organizational Characteristics	
1. Structure	
a. Grantee/delegate agency: name, type	PIR: 1, 4
b. Number of centers, classrooms comprising program	PIR: 14 A & B
c. Program modes operated: full vs. part-day, center vs. home based, etc.	
2. Funding (total, by service area)	
a. CYF Head Start grant	PIR: 12
b. Other ACYF funding	
c. Other federal, state & local	PIR: 12 C; CYF Application; Director
d. Private funding	Director
e. Donated/in-kind contributed services	Director CYF Application
3. Operating statistics	
a. Months of operation	
b. Hours of operation/child contact	PIR: 14 C, D & E: CYF Application
c. Average daily attendance among children	PIR: 16 A-4
d. Drop-out rate among children	PIR: 16 B-2d
e. Staff turnover	Director, staff rosters

[a]Abbreviations: PIR - Program Information Report (Numbers which follow the colon refer to specific PIR item numbers.)

Table 2.4 (Continued)

Contextual Variables and Sources of Information:
Head Start Administration and Organization[a]
Head Start Program Content[b]

Dimension/Variable	Source of Information
4. Staffing pattern	Organizational Chart
a. Number (total, CYF paid)	PIR: 8, 10
b. Staff positions filled (total, full- vs. part-time, paid vs. volunteer status by program unit)	CYF Application: Staff roster; Director, PIR II
c. Staffing by program area (e.g., education, health, etc.)	CYF Application
d. Selected staff/child ratios	Data Analysis
B. Program Content	
1. Major emphasis and activities	Director
2. Primary preventive aspects of other component plans/activities	Director; MH Coordinator , CYF Application (Service Plans, Cross-component plans)
3. Mental health services	
a. Major approaches to achieving objectives	ACYF application (MH Plan)
b. Relationship to other components	Director, MH Coordinator, CYF Application (Service Plans; cross-component plans)
c. Levels of service provided	PIR: 15 A, B & C, 18, 19, MH Coordinator
d. Mental health resources used	MH Coordinator
e. Staffing and organization	MH Coordinator

[a]Abbreviations: PIR - Program Information Report (Numbers which follow the colon refer to specific PIR item numbers.)

[b]See Tables 3-3 and 3-4 for abbreviations.

Table 2.5

Population Variables and Sources of Information[a]

Dimension/Variable	Source of Information
Population Characteristics	
I. Head Start Staff Characteristics	
A. Number by race and sex	PIR: 8, Staff roster
B. Number by level of training (BA or higher; degrees in early childhood education, CDA credentials)	PIR: 9 A & B
C. Consultation and training needs	Teacher
D. Staff Sample characteristics	Teacher
1. Race and sex	
2. Position	
3. Length of Head Start involvement	
4. Level of CFMH exposure (by activity)	
II. Head Start Children	
A. Number by age, race, sex	PIR: 16 B-3 & 4
B. Number by year of enrollment (1st, 2nd, subsequent year)	PIR: 16 B-2
C. Number handicapped	PIR: 16 B-1
D. Number at or below the poverty level	PIR: 16 B-1
E. Training and service needs relevant to CFMH Project	Teacher, MH Coordinator
III. Head Start Parents/Families	
A. Number at or below poverty level	CYF Application
B. Other demographic data (as available)	CYF Application; CFMH proposal

[a] See Tables 3 3 and 3 4 for abbreviations.

Table 2.5 (Continued)

Dimension/Variable	Source of Information
C. Direct service needs relevant to CFMH project	Teacher; MH Coordinator
D. Parent Sample Characteristics	Parents
1. Race and sex	
2. Length of Head Start involvement	
3. Level of CFMH exposure (by activity)	
4. Target child, family characteristics (e.g., number of children, family constellation, etc.)	Child Health Record

Table 2.6

Project Implementation Variables and Sources of Information

CFMH Services[a]

Dimension/Variable	Source of Information
CFMH Services	
I. Overview	
A. Objectives	CFMH proposals; Providers
B. Major activities & emphasis	
II. Types and levels of service	Contact & service records; Providers
A. Types, formats, content of activity models used	
B. Number of target group served	
C. Frequency	
D. Total hours of services provided	
E. Time span	
F. Characteristics of recipients by type, by problem (for crisis counseling)	Providers
III. Distribution of Services over program units	Providers
A. Number centers/other program units served	
B. Variations in levels of service according to program unit	
IV. Coordination with other Head Start activities	Director, MH Coordinator; CYF Application (Cross-component Plans)
V. Resources	
A. External resources for primary prevention, MH Services	MH Supervisor, Director
B. Other resources	Director

[a]See text for a list of "required" and "implied" services.

Table 2.7

CFMH Implementation Variables and Sources of Information:
Project History and Administrative Structure

Dimension/Variable	Source of Information
CFMH Implementation Variables	
I. Project History	
A. Planning participants	Director
B. Recruitment and staff selection	MH Supervisor, Provider, Director
C. Start-up problems	Director, Field Specialist reports
II. Administrative & Organizational Characteristics	
A. Funding and Contributed support	CFMH budget; Director
B. Staffing Pattern	
1. Number of CFMH paid staff (Total by position and % time)	CFMH proposals; Director
2. Number of CFMH paid consultants (Total by function and % time)	CFMH proposals; Director
3. Other staff providing services (including supervision)	Director
4. Other consultants providing CFMH services	Director
C. Functional Relations	
1. Duties/functions of all key staff and consultants	Job descriptions, consultant/agency contracts, Director
2. Internal communication, lines of authority among staff and consultants	Director
3. CFMH provider allocation on time to tasks/funcitons	MH Supervisor, Provider

2.15

Table 2.7 (Continued)

Dimension/Variable	Source of Information
D. Operating Statistics	
1. Provider/MH Supervisor turnover	Director
2. Provider/child ratios	Data Analysis (using enrollment and staff rosters)
3. Provider/staff ratios	Data Analysis
4. Provider/parent ratios	Data Analysis
III. Support System Components & Characteristics	
A. Collaborating agency	CFMH proposals
1. Type	Resource directory, MH Supervisor
2. Prior/current Head Start involvement	MH Supervisor
3. Training & support hours provided by Mental Health Supervisor from collaborating agency (MHW model)	MH Supervisor
a. Training provided relative to required and other activities	
b. Allocation of time according to function	
c. Hours funded	
d. Amount support provided/needed	MH Supervisor, MH Worker
B. Training & Technical Assistance Contractor	
1. Training & orientation conference	
a. Number held/attended by CFMH & other	T&TA Training conference proceedings
b. Head Start personnel	
c. Objectives, models, and activities provided	T&TA Training Conference proceedings
d. Participant evaluations	Providers, MH Supervisor
2. Field Specialist Program	
a. Objectives & Strategy	CFMH Operations Manual, T&TA proposal
b. Contacts with projects (type, frequency)	T&TA contact data sheets; Providers, Field Specialist

Table 2.7 (Continued)

Dimension/Variable	Source of Information
2. Field Specialist Program (continued)	
c. Amount of support needed/provided	Providers, MH Supervisors
IV. Characteristics of Providers, MH Supervisors, Field Specialists A. Race, sex B. Prior Head Start experience C. Other relevant experience D. Highest degrees and fields of specialization	Resumes, resume supplements, Provider, MH Supervisor, Field Specialist

2.17

Table 2.8

Project Evaluation Variables:
Perceived Outcome and Implementation Success

Dimension/Variable	Source of Information
Evaluation Variables	
I. Perceived Outcome	
A. Staff	Teacher, Provider
B. Parents	Teacher, Parents, Provider
C. Children	Teacher
II. Implementation success (Participant Perspectives)	
A. Community Linkages	
1. Appropriateness	MH Coordinators, Provider
2. Expansion due to CFMH project	Provider, MH Coordinator
B. CFMH Services	
1. Effectiveness, Quality, usefulness, etc.	Director, MH Supervisor, Teacher, Parent
2. Adequacy, quality, usefulness, etc.	Parent, teacher
3. Appropriateness, match to needs	MH Coordinator, Provider, Parent, Teacher
4. Accessibility, convenience	Parent, teacher
5. Timelines (crisis management, referral only)	Provider, Teacher
6. Coordination with other Head Start services	Director
C. Resources	Director
D. Support Services	
1. T&TA training and orientation	Provider
2. T&TA Field support	Provider
3. Field Supervision (MHW only)	Provider, MH Supervisor
E. Provider's role and functions	
1. Appropriateness, effectiveness	MH Coordinator, MH Supervisor
2. Satisfaction	Provider

Table 2.8 (Continued)

Dimension/Variable	Source of Information
F. Problems	Director, data analysis
G. Accomplishments	Director, data analysis
III. Conformity with guidelines	Data analysis (contractor, guidelines, Performance Standards)
IV. Quality	Data Synthesis: (Advisory Panel, contractor)
V. Conformity with Standards	
1. Project History	Planning meetings, minutes, Interview: Director
a. Staff participation in planning	
b. Parent/parent board participation planning	
c. Collaborating agency participation in planning	
2. Support Systems	
a. Collaborating agency participation on Health Services Advisory Committee	Board roster, attendance for HSAC meetings
b. Mental Health Supervisor participation on Health Services Advisory Committee	Board roster, attendance roster for HSAC meetings
c. Hours of supervision provided (MHW model)	MH Supervisor Interview
d. Hours/days of T&TA support provided	Field Specialist report
e. Provider, supervisor participation in T&TA provided preservice orientation and training	Interviews: provider, MH Supervisor
f. Provider, supervisor participation in subsequent T&TA training conference	Training conference attendance rosters, interviews: provider MH Supervisor

2.19

Table 2.8 (Continued)

Dimension/Variable	Source of Information
3. Characteristics of Key Personnel	Resume's & Supplements
a. CFMH provider qualifications	
b. Mental Health Supervisor qualifications (MHW model)	
4. CFMH Services	Service records interviews, consultant contracts
a. Types of activity for each recipient groups	
b. Content/focus of activities	
c. Regularity of provider contact with staff	
d. Provider's hours of service per child per month	
*5. Evaluation System	
a. Self monitoring	Interview: Director
b. Record keeping (for each required activity)	Record search
1. Frequency	
2. Number participants	
3. Time (per event)	
4. Topics presented	

*Guidelines do not suggest the form of record keeping or evaluation system. These specifications, accordingly, reflect requirements' implication of the evaluation (rather than program) contract.

2.20

Table 2.9

Project Evaluation Variables: Conformity and Quality Indices

Dimension/Variable	Source of Information	Standard
Conformity with Standards		
I. Project History	Planning meetings, minutes, Interview: Director	Guidelines
A. Staff participation in planning		
B. Parent/parent board participation planning		
C. Collaborating agency participation in planning		
II. Support Systems		Guidelines
A. Collaborating agency participation on Health Services Advisory Committee	Board roster, attendance for HSAC meetings	
B. Mental Health Supervisor participation on Health Services Advisory Committee	Board roster, attendance roster for HSAC meetings	
C. Hours of supervision provided (MHW model)	MH Supervisor Interview	
D. Hours/days of T&TA field support provided	Field Specialist report	
E. Provider, supervisor participation in T&TA provided preservice orientation and training	Interviews: provider, MH Supervisor	
F. Provider, supervisor participation in subsequent T&TA training conference	Training conference attendance rosters, MH Supervisor	
III. Characteristics of Key Personnel	Resume's Supplements	Guidelines, HSPS[a]
A. CFMH provider qualifications		
B. Mental Health Supervisor qualifications (MHW model)	Service records interviews, consultant	

[a]HSPS = Head Start Performance Standards

2.21

Table 2.9 (Continued)

Dimension/Variable	Source of Information	Standard
IV. CFMH Services		
A. Types of activity for each recipient groups		Guidelines, HSPS
B. Content/focus of activities		Guidelines, HSPS
C. Regularity of provider contact with staff		Guidelines, HSPS
D. Provider's hours of service per child per month		Guidelines
		Guidelines
V. Evaluation System[b]		
A. Self monitoring	Interview: Director	Evaluation contract
B. Record keeping (for each required activity)	Record search	
1. Frequency		
2. Number participants		
3. Time (per event)		
4. Topics presented		

[b]Guidelines do not suggest the form of record keeping or evaluation system. The specifications above, accordingly, reflect requirements implied in the evaluation. Scope of work rather than in program contracts.

Table 2.10

Description of Informational Framework

The process instruments were derived from the informational framework in Table 2.1. Brief descriptions of the major classes of variables which define that framework appear below.

Community Context. This category includes information on the demographic characteristics of each Head Start service area as well as on the mental health resources available within each service area.

Head Start Context. Head Start variables describing both the administrative structure and the program of services at each site will be obtained. Program structure will be described in terms of the funding, staffing, and internal operations of each program. Program content will be described in terms of their major emphasis, mental health services, and other program components. The description of the mental health component will include available resources, resources used, and types of services provided to staff, parents, and children.

Staff Characteristics. Staffing arrangements are described in fairly complete terms as a part of the administrative information provided on each program. The category "staff variables", consequently, consists exclusively of indices, information on staff ethnicity, sex and training.

Characteristics of Children. The population of Head Start children will be described primarily in terms of the following variables: age, sex, race, length of Head Start enrollment and incidence of handicapping conditions.

Classes of Variables	Brief Description
Community Context	
Head Start Context	

Table 2.10 (Continued)

CFMH History. Project history variables attempt to document the evaluation of each CFMH Project from its inception. Variables will permit identification of the key parties involved in planning and proposal development, a description of the process used in screening and selecting CFMH Providers, and documentation of any problems encountered in implementing the project.

Project Organization and Administrative Structure. Project organization variables parallel the administrative variables which will be used to describe the Head Start context. They include the standard indices reflective of funding, staffing, and structure, augmented by details on the functions served by CFMH Providers, CFMH supportive personnel, and other staff and consultants associated with the project. Variables describing the pattern of internal communications and the articulation of these various roles are also included.

Characteristics of Providers and Support Personnel. Descriptions of the staff and consultants who occupy the key roles on the project will be based on length of Head Start association, highest degree, areas of specialization, and any additional pre-service training or experience considered relevant to the functions served on the CFMH Project.

CFMH Services. Profiles will be developed for each type of service explicitly covered in CFMH guidelines as well as several additional types of service mentioned in evaluation guidance questions. Services in the first or mandatory category include orientation and training for parents and for teachers, special (crisis) counseling for parents, staff consultation related to primary prevention, and follow-up consultation offered in support of the classroom observations made by the CFMH Provider. Services in the second category include assistance in crisis management, consultation on curriculum program activities, and referral services.

The descriptive information on mandatory services will include: (1) type, focus, or content of service or activity, (2) frequency of each activity, (3) total hours devoted to the activity, (4) total clients served, and; (5) as appropriate, duration or time span of the activity or service. Data will be obtained from program records and from interviewing the CFMH Providers.

Family/Parent Characteristics. Little systematic information is available on Head Start parents in pre-compiled form. Therefore, the description of parents will be based on routinely collected statistics on families, which include length of Head Start involvement and incidence of families below the poverty level. The appended instruments provide additional information on the characteristics of the families who receive crisis counseling.

Table 2.10 (Continued)

Anticipated Outcomes. Questions in this category are aimed at determining the specific outcomes that each program is working to attain. The information will be obtained by interviewing CFMH Providers.

Perceived Impact. Perceived impact variables focus on the kinds of changes observed in staff, parents, and in children. Providers, teachers and parents will be asked to supply this information.

Implementation Success. This category represents the basic evaluative dimension of the process study. Accordingly, it includes information on the porject's accomplishments, any implementation problems encountered, and the project's current needs. It also includes perceptions of various aspects of the program, obtained from CFMH Providers, Head Start staff, and Head Start parents.

Supervisors are asked to evaluate the support needs of CFMH Provider, the Provider's appropriateness to the role performed, the effectiveness of the services provided, and the overall accomplishments of the CFMH Project.

Mental Health Coordinator Interview Schedules. The Mental Health Coordinators at CFMH sites are asked to supply information on the mental health service component of Head Start, his/her involvements with the CFMH Project and its staff and consultants, and coordination between the project and the ongoing mental health efforts. In addition to the descriptive information supplied in this "best source" capacity, the Coordinator is asked to give her/his impressions of the project as a whole and the CFMH Provider(s) in particular.

A parallel instrument developed for Mental Health Coordinators at control sites differs primarily in that the control version omits all questions concerning CFMH activities.

Head Start Director Interview Schedules. The Program Directors are viewed as the best source of information related to the Head Start administrative and program variables. In this connection, the Directors are asked to describe the program structure, its primary emphasis, its funding and other resources, as well as its staffing. With regard to the CFMH Project, the Director is also asked to describe the network which represents the CFMH Project interface with other staff roles and functions, the project's self-assessment system, and its implementation history. The Director also evaluates project accomplishments as well as the support available to the project through local resource agencies and professionals.

The Director Interview Schedule used at control sites covers the same area, but omits all items pertaining to CFMH operations, and includes sections covering the fate of proposed primary prevention strategies and the use of more control funds. It also concentrates more extensively on resources available for the provision of mental health services.

Teacher Interview Schedules. The effects of the CFMH Project must be mediated from the Provider through parents and teachers. Therefore, the Teacher's interview Schedule attempts to ascertain each respondent's level of participation if available and obtain an evaluation of those activities in which she/he participated. Teachers are asked to assess changes in their own behavior attributable to their involvement with the project and to assess the project's relevance to their needs. They also are asked to discuss the convenience of arrangements related to CFMH services.

CHAPTER III

CENTER PROFILES

The descriptive analysis of the nine experimental and five control sites that were included in the pilot study of the process evaluation was based on six categories selected to encompass the major categories in the informational framework in Table 2.3. The categories which served to organize the center profiles for the CFMH Projects are the following:

1. Demographic Characteristics of the Community and Head Start Program
2. History and Start-up of CFMH Project
3. Project Structure, Administration, and Coordination
4. Major Goals, Objectives, and Activities of the CFMH Project
5. Support System/Resources
6. Evaluation of CFMH Projects

Parallel categories were developed for the control sites, although the data was focused on the mental health component of the general Head Start program, since they were not funded for CFMH Projects.

The actual data contained in the center profiles was based on both written documents and data collected from the 14 centers in the pilot study and selected interviews conducted on the site visits. Table 3.1 describes the six categories or content areas included in the center profiles and the data source for each category.

Table 3.1

Center Profiles

Data Source	Categories or Content Areas
1 Census data 2 Proposals 3 Needs assessment	I. Demographic Characteristics of Community and Head Start Setting Outline demographic data on the community surrounding the Head Start center relative to socio-economic indicators such as income, employment status, and ethnic make-up. Also, provide basic descriptive information about the Head Start program, its size, number of children, number of centers, the extent to which it is center based or homebased, any special program features, other relevant children variables.
1 Head Start Director Interview #1-8; #9-10 2 Proposals 3 Program narrative	II. History and Start-up of CFMH Project Describe the process of planning, development and securing the grant including the major participants. Identification of any needs or special start-up difficulties or problems, the extent to which they were worked out or resolved, how were they overcome, and any other relevant implementation issues. The date of "start-up" of the Project; the process of selection and recruitment of provider.
1 Head Start Director #11-22 2 Mental Health Coordinator #3-7; #20-22 3 Proposals 4 Program narratives	III. Project Structure, Administration and Coordination Describe the structure and staffing of the project. How is the project administered and who is responsible within the program for program planning and coordination? To whom is the CFMH Provider responsible administratively? Who monitors the projects and is responsible for evaluating the provider? What is the mechanism for coordination of the CFMH Project with the other Head Start services and components? Who is the Mental Health Coordinator? What is their role and function and how much time is devoted to mental health? What other responsibilities does he/she have? Who are the key Providers? What is the level of training and mental health related experience of the Provider?

Table 3.1 (Continued)

Data Source	Categories or Content Areas
1 Mental Health Provider #5-9; #64-65 #11-40 2 Activity 3 Initial and continuation proposals 4 Program narratives	IV. Major Goals, Objectives and Activities of CFMH Project What are the major goals and objectives of the project? Have there been any changes in these objectives? Why? Describe the major service or activities emphasis? Specify the activities under each of the "mandated" services for the CFMH Project. How many sessions conducted, their frequency, total number of hours, number of recipients, etc.? What was the nature and extent of direct services to children?
1 Mental Health Supervisor #1-21 2 Mental Health Coordinators #24-27	V. Support Systems/Resources Describe the mental health organization or professional which collaborated with the Head Start program in developing or implementing its CFMH proposal, nature of supervision or other supports under the Mental Health Worker Model, frequency of services, etc. List and describe the outside agencies that are "viable" resources for developing a primary prevention program. What traditional mental health services are available and/or utilized to assist the Head Start program? What non-traditional resources are used as resources? How effective has the project involved local mental health agencies in program?
1 Head Start Director #35-42 2 Mental Health Coordinator #28-36 3 Mental Health Supervisor #22-27 4 CFMH Provider #61-63; #66-67	VI. Evaluation of Project and Provider's Role From the vantage point of Head Start staff Director, Mental Health Provider and the Mental Health Supervisor, describe: The effectiveness of the project overall; the adequacy of coordination; the adequacy and appropriateness of supervision; the effectiveness in involving and utilizing outside agencies. Also indicate the extent to which the Mental Health Provider is satisfied with his/her performance and their perception of changes in Head Start program, parents, staff of teachers as a result of interventions.

Appleton City, Missouri (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Head Start Project, operated by the West Central Missouri Development Corporation is located in Appleton City, a small rural town with a population of 133,767. The Head Start program serves a nine county area that includes Bates, Benton, Cass, Cedar, Henry, Hickory, Morgan, St. Clair, and Vernon Counties. The geographical area served is 1600 square miles which includes only one population center in excess of 10,000 people. According to the 1979 census, 27.5% of the area's 136,000 population subsists on income less than the federal poverty level. The median income level by county is $6,500 for Bates county; $5,439 for Benton; $8,707 for Cass; $5,335 for Cedar; $6,511 for Henry; $4,727 for Hickory; $6,015 for Morgan; $4,865 for St. Clair; and $6,237 for Vernon. Census data also indicate that the unemployment rate ranges from a low of 2.4% in Morgan county to 4.5% in Benton county. The median educational level, by county, is listed below:

County	Educational Level
Bates	10.4
Benton	9.0
Cass	12.2
Cedar	10.1
Henry	11.1
Hickory	9.4
Morgan	10.2
St. Clair	10.0
Vernon	11.1

The Appleton City Head Start program which is now completing its thirteenth year, provides the full complement of nutritional, health and educational services as prescribed by federal regulations governing project operations. In addition, the program has provided Early and Periodic Screening, Diagnosis and Treatment (E.P.S.D.T.), supportive services to handicapped children, and, a "multi-disciplinary evaluation team" that provided data necessary to create an expanded health services project for thirteen counties.

Currently, the local Head Start program, which has a budget of $332,040, serves 225 children, the majority of whom are from families whose income is below the poverty level. The program runs four days a week for eight months. The fifth day of the week is utilized for curriculum planning, staff training, staff conferences related to children and families, and special activities. There are nine separate centers, one in each county. Consistent with the ethnic distribution of the surrounding communities, the enrollment is composed of 217 whites, 7 blacks and 1 Chicano.

II. History and Start-up of the CFMH Project

The development of CFMH Project was based on the already identified need for primary prevention services due to the unavailability of resources in a rural isolated area. At the time that the Head Start program submitted the initial CFMH grant proposal in the Spring of 1977, it was the consensus of the local Head Start Director, the teachers and other staff and the Health Services Advisory Board, that there was a widespread need for preventive mental health services for all the children and that approximately 17% of the children fall within the "at risk" category. The personnel involved in the process of the initial proposal development included the Head Start Director, the Health and Educational Coordinators, representatives of the teaching staff, and a Mental Health Professional.

In documenting the need for CFMH services, the initial proposal enunciated the need for preventive services. The rationale provided for seeking monies for preventive services was based on the fact that although there was a state-supported hospital that provided an array of mental health services, its primary emphasis was custodial care for in-patients and out-patient services for adults with more severe emotional disturbances. Similarly, the proposal noted that the existing Mental Health Professional contracted by the Head Start program on a part-time basis, provided diagnostic and treatment services that were more in line with secondary prevention, in order to comply with minimum standards developed by the Administration for Children, Youth and Families. Further, the disadvantage of having a Mental Health Professional from outside the service area and the program expense involved in securing the necessary mental health services demonstrated the importance of implementing the CFMH Project. The program chose to provide the necessary services and to minimize these problems by using a paraprofessional indigenous to the local population as the principal Mental Health Provider.

Although there were no major start-up problems, there were some initial reservations among the teaching staff about the utility of the Mental Health Professional. However, according to the Head Start Director, these were resolved satisfactorily. In addition to these minimal start-up problems, the project identified the following problems experienced in implementing the CFMH Project during the first year:

1. Too many staff meetings;

2. Having children unattended at site of meeting was disruptive;

3. Needed set dates for meetings as opposed to setting them after every meeting.

4. If less than two meetings a month were held, parents tended to lose interest and we seemed to be unable to maintain rapport;

5. Limited parent interest in some centers regarding CFMH;

6. Having CFMH and regular parent meetings combined caused problems;

7. Switching group leader (psychologist) caused resentment and loss of interest in some parents;

8. Parents had specific problems they wanted solved.

Nevertheless, the problems were sufficiently resolved to allow the program to secure the following accomplishments during the 1977-78 year as a result of the CFMH Project:

1. Provided programs for parents and staff designed to increase insight into their self-motivation and to understand the "rightness" of alternative behaviors;

2. Assisted parents in acquiring better parenting techniques;

3. Helped parents identify, discuss and apply different approaches to discipline;

4. Helped develop more self-confidence for parents by creating situations in which they could see themselves as successful;

5. Eased marital tensions with some eight families;

6. Intervened in crisis situations (i.e., divorces, deaths, etc.) where it will affect the child's well-being (emotionally);

7. Parents and volunteers learned techniques for positive reinforcement;

8. Parents were able to identify, discuss, and apply realistic expectations to life situations;

9. Helped solve present personal problems that were asked and at the same time, taught methods for avoiding similar problems in the future;

10. Reinforced positive parenting skills presently established;

11. Acquainted parents with positive aspects of mental health workers while dispelling false notions about same;

12. Encouraged parent interaction in groups to dispel notions of uniqueness of problems.

III. Project Structure, Administration and Coordination

As a result of the financial problems in securing the services of a Mental Health Professional, outlined in the initial grant proposal, the Appleton City Head Start program opted for the Mental Health Worker Model, involving a paraprofessional indigenous to the community and a Mental Health Supervisor. The staff of the CFMH Project has remained the same since its inception in 1977.

The overall administration of the proposed project was the direct responsibility of the local Head Start program which has overall administrative responsibility for program, and, is responsible for monitoring and evaluating staff performance. The evaluation is implemented by the Program Evaluation and Review Technique (PERT). Fiscal responsibility and grants management reside with the sponsoring agency, the West Central Missouri Rural Development Corporation.

The day-to-day coordination between the CFMH Project and the mental health component of Head Start is handled by the Mental Health Coordinator, who also holds the position of Health and Handicapped Coordinator, who estimates that she spends approximately 24 hours per month in performing mental health related activities within Head Start. The principal responsibilities of the Mental Health Coordinator involve securing the services of mental health personnel, insuring adequate follow-up when referrals are made, and that implementation of recommendations by the Mental Health Professional are completed. Although the Mental Health Coordinator has no specific responsibilities to the CFMH Project, she does interface with the project in coordination between the various service components through case conferences with teachers, medical, social services, etc. at the center level, and, where appropriate, written plans are presented.

The key provider of mental health to the CFMH Project is a Mental Health Worker, a paraprofessional who is a long-time resident of Appleton City having previously been employed as a nurse's aide and medical assistant. She is employed 100% time and is supported by an educational psychologist, who, according to the budget, is contracted to provide thirty-seven (37) hours of supervision and consultation to the CFMH Project per month, in addition to his responsibilities for providing mental health services to the total Head Start program. Specifically, he is responsible for providing testing and evaluation of children for nine days per month, preparing psychological reports, conducting classroom observations and case conferences with staff and parents.

IV. Major Goals, Objectives, Activities of the CFMH Project

The goals and objectives of the Appleton City program are in accordance with the broad guidelines for the CFMH Project prepared by the Administration of Children, Youth and Families. However, in addition to the guidelines, the local program set the following goals to:

1. Involve Head Start staff and parents in meeting the child's social, emotional and intellectual needs in ways appropriate to his or her developmental level;

2. Develop and test the Child and Family Mental Health Worker model of primary preventive mental health services;

3. Collaborate with other local agencies in development of the local CFMH Project in a manner that will meet local community needs;

4. Develop necessary administrative mechanisms that will guide the planning and implementation of CFMH on the local level;

5. Provide data resultant from CFMH Project operation for use in evaluation of program activities;

6. Demonstrate the replicability of the local CFMH model.

According to the estimates of the Mental Health Worker, the major service emphasis of the Mental Health Worker was in the area of staff training and, secondarily on classroom observations and staff consultation. However, other services provided to a lesser extent were staff training and crisis-counseling.

Consistent with the primary preventive thrust, service records indicated that there were neither formal diagnostic screening of treatment services provided to Head Start children by the CFMH Project. In fact, contractual agreement, and other service records indicate that such secondary preventive services were provided on a contractual basis by the Mental Health Supervisor, using general Head Start monies.

Orientation for Staff and Parents

According to the Mental Health Worker, the CFMH Project conducted separate orientation sessions for staff and parents at each of the Head Start centers. The objective of these orientation sessions were to familiarize the participants with the goals, objectives and specific plans for the program. The Mental Health Worker estimated the orientation sessions for staff generally lasted for half-an-hour, each receiving training occurring twice per month. The sessions were generally of two hours duration and topics were

selected for presentation by the parents. The main topics or issues covered were alcoholism within a family, parenting for single parents, assertiveness training, modeling as a parent, etc. Staff estimates indicate that there were 67 training sessions over a period of eight months with an approximate total number of hours of 134. The number of parents participating were between 45-50. Crisis counseling was provided by the Mental Health Supervisor to eight parents over a program year. Generally, the Mental Health Worker accompanied the psychologist during the crisis counseling. The types of presenting problems for crisis counseling were divorce, death of family member, a disaster (i.e., fire) and a child abuse case. On the average, the crisis counseling sessions were conducted in two sessions that met in consecutive weeks for approximately one hour per session. Thus, an estimate of 16 hours were devoted to crisis counseling during the 1978-79 program year. Approximately three of the parents receiving crisis counseling were referred to an outside agency for counseling. The type of problems for which the referrals were made were mental conflicts and adjustment problems related to separation from a mate.

Services to Children

The Mental Health Worker and the Mental Health Supervisor reported that the CFMH Project provided no screening, diagnostic or treatment services to children.

V. Support System/Resources

The implementation of the Child and Family Mental Health Project was assisted internally by the Mental Health Supervisor whose primary responsibility was to provide training and supervision for the Mental Health Worker, and, was available for mental health consultation to parents about issues related to their children. The supervisory sessions with the Mental Health Worker are generally for nine hours per week. The supervision covers psychological theories and principles related to personality development, psychopathology and treatment approaches, case discussions of children or group dynamics of parent education sessions. The most common topics or issues initiated by the Mental Health Worker were problems related to child behavior and interpersonal problems with parents. The type of general feedback provided included assistance in formulating diagnostic issues, recommended interventions, and limits of the professional relationship given the nature of the Head Start setting. Also, specific training was provided for parent counseling in terms of methods of support and reassurance, relationship building, and increasing the ability to empathize with parents.

The CFMH Project utilized outside agencies to a very limited extent, although the community counseling center is run

by the Head Start staff, as being a viable resource for providing outreach services into the home.

VI. Evaluation of CFMH Services

Overall, the Head Start Director, the Mental Health Worker and the Mental Health Suerpvisor reported that they were "very satisfied" with the CFMH Project and the performance of staff. In fact, the Mental Health Worker who was closest to the program activities felt that as a result of the CFMH Project there were identifiable changes in Head Start staff and parents. Specifically, she viewed the staff as more confident, demonstrated more consistency in child management approaches, and used "time out" periods in the classroom more effectively. She also reported that she had observed among the parents, more effective parenting skills and more positive self-esteem in their own lives, and were able to communicate more effectively with other parents. The Mental Health Supervisor concurred with the above mentioned changes in parents and also noted that parents were more spontaneous in expressing themselves and there seemed to be more parental reports of harmony and fewer family conflicts at home.

Berkeley, California (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Berkeley, California Head Start program services the urban community of Berkeley, California, which is part of the larger metropolitan San Francisco/Oakland Bay Area. The population of Berkeley is 116,716, with 23% of the population being Black, 68% being White, and 5% of Spanish origin. The median family income for the city is $9,987, with 18.2% of the population or 10% of the total number of families having incomes below the poverty level. The median education level for Berkeley is fairly high - 14.3 years. This statistic is clearly influenced by the presence of a University of California campus in the city.

The Berkeley Head Start program is funded for $225,247 to operate five centers. Six classrooms serve the total of 117 children in the program. There is one class per center in each of three centers. One of the remaining two centers contains two classes of children, while the last center provides a home-based component. Each of the standard classrooms operate Monday-Friday, 9:00 a.m. -3:00 p.m. The Home Visitors program operates Mondays, Wednesdays and Fridays from 9:30 a.m.-1:30 p.m. and holds classes at a central location (New Light Baptist Church) on Tuesday and Thursday mornings. The racial composition of the program population for all five centers is as follows: 60% of the students are black, 17% are white and 3% are Chicano. The vast majority of the children in the program are four years old; only 23 of the 117 children are two or three years old. No five-year-old children are included in the program.

II. History and Start-Up of CFMH Project

The proposal for Berkeley's Child and Family Mental Health Project was a joint project of the Head Start Director, a local mental health agency (Berkeley Family Services Agency), and the CFMH Consultant. It represented the development of a priority area that had been identified by the Head Start Parent Board. Once finalized, the proposal and CFMH guidelines were presented to the Board of Directors of the Berkeley Family Services and the Health Services Advisory Committee of the Berkeley Head Start program for the approval. The approved proposal was subsequently submitted for funding to ACYF.

The Berkeley CFMH Project began operating in September 1977. The project was originally funded for $14,000. The program's funding for the '78-'79 fiscal year was increased to $16,000. This included salaries for a half-time Mental Health Consultant and a 1/4 time

secretary. This staffing pattern has existed since the program's inception. The staffing has remained virtually unchanged, with the replacement of the project secretary occurring as the exception. Additional funds allowed for only irregular, as-needed use of the consultant.

The Director of the Berkeley Head Start program reported no start-up difficulties in initiating the CFMH Project's component. However, changes were made in the continuation proposal reflecting the first year's evaluation of the project by Head Start staff and parents. These changes in activities are reflected below.

III. Project Structure, Administration and Coordination

The primary staff person for the Berkeley Child and Family Mental Health Project is the Mental Health Consultant, who is the primary provider in the project. Ruth Beard, a licensed clinical social worker, has been the consultant since inception of the project. She has 10 years experience in pediatric social work as well as experience as a consultant to child care and Head Start centers in San Francisco.

The structure of the Berkeley CFMH Project required that the Mental Health Consultant report to the Head Start Director. As the primary staff person, Ms. Beard functioned as the Mental Health Coordinator as well as fulfilling the role of Mental Health Consultant, performing the following duties:

1. Training and consultation of staff and parents;

2. Development of a program in preventive mental health;

3. Designing experiences which exemplify mental health techniques;

4. Development of forms which assess needs for the area of preventive mental health.

5. Materials for use in preventive mental health practice and evaluation formats.

She was also responsible for accomplishing all of the designated goals and objectives of the Berkeley CFMH Project. As Mental Health Coordinator, Ms. Beard met weekly with other Head Start component coordinators to effectively coordinate their various activities and objectives. In addition, a monthly report was submitted by Ms. Beard to the Health Services Advisory Committee of Berkeley Head Start, the Berkeley Family Services Agency, and the Head Start staff. Monitoring of the project was the responsibility of the Field Specialist.

Martin Glasser, M.D., assigned to the program by the Training and Technical Assistance Contractor for the '77-'78 program year.

IV. Major Goals, Objectives and Activities of the CFMH Project

The goals for the Berkeley CFMH Project were defined as follows:

"Through the use of demonstrations, workshops, and group discussions for both parents and staff to:

(a) Heighten the awareness of each as to the role they play in the mental well-being of the child;

(b) Train them in techniques which encourage healthy mental functioning in themselves and children;

(c) Produce materials which contain simple suggestions related to normal child development and human experiences;

(d) Involve parents and staff in evaluation of success of efforts."[4]

Also due to the predominance of blacks among their service population, the Berkeley CFMH Project sought to utilize techniques, activities and educational information that had been examined and judged as being relevant to the differing communication styles and family interaction patterns of black people. Finally, staff set the goal of developing and utilizing materials and activities that required involvement and participation from parents and children alike.

In the interview, the Mental Health Consultant expressed the objectives of the project as being to "demonstrate a preventive method with a family orientation to mental health; to train parents and teachers in skills which will encourage the children's positive mental development." These reflected her view that the objectives for the '78-'79 program year were more parent-oriented than in '77-'78 when the project had a greater staff focus. Both staff and parent training were, however, identified as requiring the greatest time commitment during the project's second year.

The Consultant's activities for both years included: parent and staff orientation and training, staff consultation, and classroom observation plus follow-up consultation with staff. In addition, for '78-'79, the Berkeley CFMH Project identified several activities as means of accomplishing the project's general goals. These included:

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[4] As reflected in their '78-'79 continuation grant proposal.

1. A newsletter column written by the Mental Health Consultant in the Head Start program's monthly newsletter;

2. A monthly "Family Night" which included planned activities for parents and children held both jointly and separately. (These activities were based on the principals of Positive Parenting as developed by the National Family Skills Center).

3. Special workshops for parents and staff.

4. A parent class (as a part of "Family Night") for which parents could get college credit.

Orientation for Staff and Parents

Previously, some concern had been expressed that the teachers had not been fully oriented during the first year of operation of the program. Three orientation sessions, lasting a total of eight hours, were held in the beginning of the '78-'79 program year to orient the staff to the project's goals, objectives and planned activities for '78-'79. In addition, the Consultant met with each teacher to discuss the program and get their input regarding directions in which they wanted the program to go. Staff orientation was also addressed through meetings with the other component coordinators and presentations at staff meetings.

Orientation of parents to the project was accomplished through holding a one-hour orientation session at each of the six Head Start centers. Approximately 30 parents were oriented at these sessions. Various written materials were handed out and pertinent information was presented at the monthly parent meetings.

Staff Training, Child Observations and Consultation

Three one-hour staff training sessions were conducted by the Mental Health Consultant in '78-'79. These focused on stress management and general issues relevant to parenting. Approximately 20-25 staff attended these sessions.

In addition, the Consultant observed classrooms once a week throughout the year. Thus, over the year, all six classes were observed for: teacher-child interaction; the effect of the environment on the children; child-child interaction; children's experiences with the information being presented; and special problems or needs. Observations were usually 2-3 hours long and were immediately followed by consultations with the staff. In the course of the consultations with the staff, the Consultant would present her recommendations based upon that observation session. During the course of the year, she also made observations and recommendations to the

administrators of the centers regarding changes in the classroom environment, changes in groupings of children, and increasing the use of already existing equipment.

Parent Training and Crisis Counseling

Much emphasis was placed on parent training during the '78-'79 year. Parent education was accomplished via "Family Nights", parent education classes, and the monthly newsletter articles written by the Mental Health Consultant. Staff and parents were involved in the selection of topics for parent education. Some of the major issues covered during the year were stress, positive parenting, human development, values, personal differences, communication, discipline, and planning. Six "Family Nights" were held over the year with additional parent training at the weekly parent meetings. During the course of the year, all parents participated in some part of the parent education component.

In compliance with the primary prevention orientation of the CFMH Project, no direct treatment services were provided to parents by the Mental Health Consultant. In crises, the Mental Health Consultant was called upon to make appropriate referrals. This situation occurred three times during the '78-'79 year. In each case, the mother was identified as needing additional services and referred to other agencies.

Services to Children

The Berkeley program provided few direct services to the children. Occasionally, children were referred to the Consultant for psychological assessment or testing. Also, the Consultant came into contact with the children in the course of "Family Nights" and classroom observations. Otherwise, most contact with children was indirect through staff and parents.

V. Support System/Resource

The Berkeley CFMH Project is the product of efforts from both within and outside the Berkeley Head Start program. The Head Start Director provided the most support internally, while the primary external support came from the Berkeley Family Services Agency.

With respect to external resources, the Berkeley CFMH Project and Berkeley Head Start have the good fortune of being located in an area with a wealth of mental health programs and services which they can utilize as resources for themselves and the population they serve. Thus, the CFMH Mental Health Coordinator can call upon the resources of several traditional mental health agencies as well as other organizations offering primary or secondary preventive services such as the YMCA, the YWCA, etc.

VI. Evaluation

Evaluation procedures developed by the CFMH Consultant in conjunction with the Head Start Director included evaluation questionnaires. The Head Start Director rated the Berkeley CFMH Project as generally effective with the greatest effectiveness being achieved through the counseling with teachers, the parent education class, and "Family Night." Notably, the Berkeley Head Start Director was unable to identify any particular problems interfering with the program's effectiveness.

In the interview, the Mental Health Coordinator/Primary Provider expressed general satisfaction with the project, her role in the project, and her execution of the tasks for which she was responsible. She also viewed the CFMH Project as being generally effective in involving local mental health agencies and professionals in parent and staff activities. Finally, she noted that parents had reported that the program had a positive impact on them by increasing their feelings of effectiveness in their lives and in raising their children.

Teachers and parent interviews supported the generally positive evaluation of the Berkeley CFMH Project. Both parties acknowledged having been involved with CFMH activities and expressed a general satisfaction with these experiences.

Bridgeton, New Jersey (Experimental)

I. Demographic Characteristics of the Community and the Head Start Program

The Southwest Citizens Organized for Poverty Elimination (S.C.O.P.E.), a community action agency in southwest New Jersey, administers the Head Start program which serves Cumberland, Gloucester, and Salem Counties. Over 354,000 people reside in the 1,194 square-mile region. The majority of the population in the tri-county area, 88%, are White. Blacks and other ethnic groups constitute the remaining twelve percent.

Economic conditions vary among the three counties. Cumberland, the largest county, contains several areas with moderate to high concentrations of poverty. Eleven-and-eight-tenths percent of all individuals, and 9.2% of the families in this county are classified as having incomes below the federally-established poverty level. The median family income in Cumberland, $9,529, is the lowest of the three counties.

In Salem County, the second largest, though fewer pockets of poverty exist, the number of families living in poverty is still relatively high (8.5%). The median family income here is $10,221, not significantly more than that of Cumberland. The unemployment rate in Salem, however, is relatively low as compared to those for Gloucester (..0%) and Cumberland (5.7%) Counties.

Though predominantly rural, the median educational levels for these counties range from 10.7 to 11.8 years. The drop-out rate among teenagers, 3.5%, for Gloucester County is the lowest in the region. Yet, in both Salem and Cumberland a larger portion (1/16) of the children 14-17 years old, have left school.

The S.C.O.P.F. Head Start expanded its program in late 1978 to serve 378 children from the three counties in southwest New Jersey. Located approximately 60 miles from Atlantic City, the program's centers were nevertheless operating in basically rural and sparsely populated areas. Thus, to some extent, Head Start and the other programs administered by S.C.O.P.E., represented an essential network of social services for families in Salem, Gloucester, and Cumberland Counties.

Children from 3-5 years attended the eleven Head Start centers run by S.C.O.P.E. All centers are open year-round, generally operating from 8:30 to 3:00. Three of the centers--Deptford, Penns Grove, and Vineland conduct two sessions daily, while the remaining centers have standard, single-classroom programs.

As previously mentioned, minorities comprise only a small proportion of the total tri-county population. In contrast, the children en-

rolled in Head Start are predominantly black (approximately 67%). White and Hispanic children comprised 25% and 8% of the program, respectively.

The S.C.O.P.E. administrative headquarters, having recently moved to new, larger facilities in the urban community of Bridgeton, is approximately 25 miles from the Cumberland County Guidance Center, the collaborating mental health agency. The program's centers, too, are located at varying distances from the administrative offices (ranging from 5 to 30 miles) and are only accessible by two-lane highways. So not surprisingly, both Head Start staff and Guidance Center Consultants spend large amounts of time traveling between centers and their home bases.

II. History and Start-up

The availability of CFMH funds provided an opportunity for the Bridgeton program to implement previously developed plans related to the provision of mental health services to the Head Start population. Particularly because the families within the three-county region served by the S.C.O.P.E., Head Start historically did not utilize the available mental health services, the CFMH Project seemed an especially efficacious strategy for reaching those families who potentially would benefit from receiving such services.

Through the concerted efforts of the Head Start Director and staff, and the previous Director of Consultation and Education at the Cumberland County Guidance Center, the planning for a preventive mental health service began. The final proposal, developed by the Director and Consultant, was funded in July 1977 for $25,000 to serve 250 children.

During the initial implementation period, the CFMH Project experienced only minor difficulties. First, staff found it difficult to obtain the desired level of parent participation at the various centers. Second, as the Director indicated during an interview, the staff somewhat over-estimated the time, efforts, and activities necessary to complete excessive scheduling of activities resulting in lowered parent participation and conflicts with other staff.

Other problematic areas, identified by the staff, consultants, and Planning and Human Systems Field Specialist, included:

1. The lack of staff orientation to the terminology and consultant roles/responsibilities related to the CFMH Project;

2. Limited staff participation in consultation;

3. Scheduling conflicts and lack of transportation resulting in a decrease in expected parental involvement;

4. Insufficient orientation to Head Start goals and philosophy was provided to new consultants, and;

5. The absence of a standardized record-keeping system to maintain information related to classroom observation, staff consultation, and contact with parents.

These issues, however, were addressed and strategies for resolution later developed through joint meetings between the Head Start and Guidance Center staffs. Additionally, the support and technical assistance of the Field Specialist proved an invaluable resource the first year of the project's operations.

During the recruitment and selection process, the Guidance Center Director of Consultation and Education, played an important role in helping Head Start to find Consultants who, in addition to having experience in working with young children, would be sensitive to the needs and values of the low-income families served by the program. Two other consultants from the mental health facility--the Coordinator of Children's Services (a clinical nurse) and a staff psychologist--were selected along with the Guidance Center Director of Consultation and Education, to work with staff and parents.

III. Project Structure, Administration and Coordination

Under the Community Resource model employed by the Bridgeton Head Start, consultants served as the principal Mental Health Professionals within the CFMH Project. During 1978-1979 project year, two psychologists and a social worker were provided from the Cumberland County Guidance Center to serve the centers in the Bridgeton program. Two of the consultants, replacements for those who originally worked with the CFMH Project, began working with the program in the Fall of the second year.

To facilitate the implementation of the CFMH Project and its effective delivery of preventive mental health services, the Head Start staff and the providers from the Guidance Center, collaborated to delineate the roles and responsibilities of all participants within the 1978-1979 Mental Health Plan. Specifically, those for the Mental Health Professionals required that they:

1. Visit each center to observe classes and participate in team planning with center staff and parents regarding effective interaction and intervention techniques;

2. Be cognizant of the fact that mental health services to Head Start families seek wellness and provide solutions for problems of real children in real settings;

3. Practice and advocate mental health by not limiting services to children and families who have developed problems;

4. Observe and interact in classrooms with staff, parents, and children to foster an environment of acceptance;

5. Display an awareness of cultural, racial, and ethnic differences in parental view of children's behavior and development; and

6. Possess an ability to work with people of varying educational and motivational levels and from different ethnic/cultural backgrounds.

The project funding provided for the Mental Health Providers to work with the project on a half-time basis, serving on-site approximately two to three weeks each month. Consultants were generally assigned to work at specific centers, though they occasionally might be delegated other duties on the basis of their disciplines, experience, and expertise. One of the psychologists, selected because of personal interest and relevant experience in consultation and education, assumed overall responsibility for informal coordination of activities among the consultants and external coordination with Head Start staff.

Within the Head Start program, the Director handled the majority of the administrative and fiscal matters associated with the project, while the Special Needs Coordinator oversaw the day-to-day monitoring of CFMH activities and services. The Special Needs Coordinator, formerly the Bridgeton program's Health/Handicapped Coordinator, was principally responsible for general project planning and scheduling of activities. She also maintained training and services records; monitored and evaluated service delivery and follow-up; observed children to insure the validity of staff/consultant evaluations; and insured coordination between Head Start and the Guidance Center. Other duties related to the provision of handicapped (special) services and the mental health component additionally were within the domain of the Special Needs Coordinator.

Though no formal procedures had been developed to monitor the CFMH Project, the Special Needs Coordinator worked closely with the Mental Health Providers, center staff, parents, and the Health Services Advisory Committee (HSAC) to obtain feedback regarding their specific concerns, project effectiveness, or suggested changes within the project. However, specially designed survey instruments were administered during the year to assess parental and staff interests, concerns, recommendations, and evaluations of CFMH services and activities.

The HSAC also played a special role in the administration, monitoring, and evaluation of the CFMH Project. Its membership included the representatives from several social and community agencies in the tri-county catchment area, a Guidance Center Consultant, and the Head Start Director. The Committee met four times throughout the

year to receive status reports, assist in the development of the CFMH Project and mental health plans, and implement decisions about the project. Thus the HSAC had many functions which included serving as:

1. A liaison between these various resource agencies;

2. A network for dissemination of important information related to mental health, primary prevention, and the CFMH Project, and;

3. A mechanism for review, evaluation, and planning.

All service coordinators in the Bridgeton program shared a large, communal office space. The physical working arrangement appeared to facilitate the exchange of information, program planning and monitoring, and the discussion of upcoming events. These frequent daily, informal contacts between the coordinators, along with weekly staff meetings, served to fully integrate the CFMH Project into the other on-going Head Start service areas.

In addition, the Head Start staff was keenly aware of the necessity of maintaining effective coordination between CFMH activities and services with those of other component areas. Since many of the general services provided by Head Start are preventive by their very nature, the staff worked especially hard to avoid scheduling conflicts and the duplication of efforts, activities, and services in implementing the Child and Family Mental Health Project. The program's social services, in-service training activities, and parent training/involvement component, in particular, often included topics, activities and services which were closely related to mental health, in general, and the CFMH Project specifically.

IV. Major Goals, Objectives and Activities

The S.C.O.P.E. Head Start program, with the assistance of Consultants from the Guidance Center, developed primary prevention-focused activities and services which would enable principal caregivers--parents and center staff--to provide positive social and emotional environments for children, thus fostering their health, growth and development. In support of this primary goal, orientation activities, staff and parent education/training, observation and consultation services, as well as crisis/support counseling were available through the CFMH Project.

Orientation for Staff and Parents

The main objectives of the orientation for both staff and parents were to (1) acquaint them with the CFMH goals, activities, and implementation plan for 1978-79, (2) outline their specific roles and responsibilities within the project, and (3) elicit suggestions

regarding how to implement the CFMH Project at individual centers. During the months of September and October, special two-hour meetings were scheduled at centrally located Head Start centers in each county to enable parents and staff to meet the second-year project consultants and to discuss any issues of concern they might have. Other recreational activities, such as arts and crafts workshops, were arranged in conjunction with the mental health component.

An additional three-hour orientation session was conducted jointly for the total program staff. At this time, the regional administrative staff, along with the consultants, met to discuss in-depth, the concept of primary prevention and receive pre-service training regarding the specific procedures involved with participation in the CFMH Project.

Parent Education and Training

The education and training activities formed a major portion of the CFMH Project. Consistent with the concept of primary prevention, they were designed to:

1. Provide parents with skills that reinforce parental strengths, thereby enhancing their child's growth and development;

2. Provide experiences which promoted positive feelings among parents about themselves, their children, and their family unit;

3. Demonstrate developmental activities which contributed to social competence and positive interfamilial relationships, and;

4. Help parents develop a positive attitude toward mental health and the utilization of psychological services.

Various monthly activities were conducted to increase parent involvement with Mental Health Consultants, Parent Trainers, and Family Workers. For example, "rap" sessions were held at each center on a monthly basis to facilitate the development of a network of emotional and social support for parents. This seemed a particularly vital aspect of the CFMH Project at those centers operating in rural seetings, where families might tend to experience greater isolation.

Three parent training modules--"Getting in Touch with Feelings," "Effective Parenting," "Child Management"--were conducted in the S.C.O.P.E. Program for groups in each county throughout the project year. Most often the parent training activities, having been restructured based upon first year information, took the form of small group discussions or larger interactive workshops with staff, parents, and children present. Specific topics under training seg-

ments included behavior modification techniques, normal child development, child management vs. discipline, case studies, communication and coping with stress. Audio-visual aides, books, handouts, and other materials either developed or selected by the Head Start staff and consultants, were frequently available to parents. A rather comprehensive bibliography for the project, given in the 1978-79 CFMH plan, included, for example, a training kit on "The Art of Parenting;" a pamphlet, "What Everyone Should Know About Mental Health Services;" and various HEW materials on stress, guilt and relaxation.

Parent/Family Counseling

Under the CFMH guidelines group, family, and individual counseling were available for those parents who required such services. Twenty-two hours of consultant time were allocated during the 1978-79 year to provide short-term counseling and crisis intervention through the Guidance Center to help parents and staff cope with personal, professional, and familial problems or crises. Counseling sessions might occur informally as home visits or brief supportive contacts within a center. In other cases, private individual therapy sessions would be arranged with Guidance Center staff or consultants from other appropriate agencies within the counties.

During the project's second year, relatively few parents from the S.C.O.P.E. centers sought crisis intervention/counseling services. Less than ten parents received assistance from the consultants, requiring approximately twenty-five hours of counseling. Generally, parents attended only one (1) two or three hour sessions during the year to cope with concerns such as marital relations; handling specific child behavior; or sexual/child abuse. Fewer than 30% of the parents who sought help required more intensive therapy, different services, or had to be referred to other outside agencies.

Although parents in the tri-county region tended not to utilize traditional mental health services, the Special Needs Coordinator reported that they often were likely to discuss personal problems or seek psychological support from friends, family, or other Head Start parents with whom they were close.

No formal procedures for documenting crisis intervention/counseling services was used by the S.C.O.P.E. program. The consultants, however, usually kept general notes regarding the nature of their contact and any recommendations or follow-up services. The Special Needs Coordinator indicated that the need for a standardized record-keeping system for counseling services had been identified as a priority to be addressed in the upcoming year.

Staff In-Service Training

In addition to objectives directly related to fostering child growth and development, the staff in-service training was intended to

increase staff understanding and skills regarding their interaction with parents. Therefore, major training for administrators, teachers, teacher aides, and support staff focused on child development, management, communication skills, and counseling and leadership. At least 30 hours of training were conducted by consultants under the CFMH plan.

The child development module, consisting of four sessions attended by center staff, were provided to each of the three county groups. These sessions included discussions of normal child development, recognition of and planning based upon individual child needs, and strategies for helping children adapt to the classroom environment. Staff also received specific training in the use of S.C.O.P.E. assessment instruments, observation forms, and developmental records.

Conducted jointly with parents, two formal child management sessions were held at each center. These presented the opportunity for staff and parents to express their concerns about child-rearing, share feelings and ideas about working with children, and develop strategies for effective parenting and teaching.

The communication skills and counseling/leadership models, each comprised of four sessions attended by total staff, were primarily aimed at:

1. Facilitating communication between staff and fostering positive attitudes about child-rearing, and;

2. Increasing staff's knowledge of human behavior and dynamics.

Through didactic training, as well as group discussions, staff learned to recognize, understand, and cope with their own problems and to become more effective in helping others. Effective listening skills, group leadership techniques, and identification of group roles and responsibilities were important topics addressed during in-service training.

General reports on training sessions and attendance were kept by the Special Needs Coordinator at the administrative office. These usually contained brief descriptions of the structure, training models, and materials used for each training activity. Other descriptive information on in-service training was kept by the program's Education Coordinator.

Classroom Observation/Consultation

Perhaps the most important aspect of the CFMH Project was the classroom observation and follow-up consultation provided to each class within a center. Observation and consultation, services which sometimes included informal training, were designed to increase staff's ability to plan for, and meet individual child needs; to involve them

in planning, implementation, and evaluation of the CFMH Project; and to assist teachers in recognizing the adult attitudes, behaviors, and classroom or home environments which contribute to healthy emotional development.

Regularly scheduled on a monthly basis, observations focused on staff /child interactions, the classroom as a whole, in addition to specific children's behavior. By identifying staff needs and concerns, consultants were able to help teaching staff capitalize on their particular strengths and abilities while working with children. During follow-up consultation, individual teachers and aides had an opportunity to discuss their concerns; receive answers to questions about a child or problem; and get feedback suggestions; and more importantly, receive praise specific to their pedagogic styles.

The Mental Health Consultants consistently emphasized the concept of primary prevention by assisting teachers in developing and utilizing intervention techniques, rather than requesting treatment or referral. Through individual consultations and follow-up, teachers gained the insight and confidence to effectively assess and handle certain classroom situations or child behaviors, for which previously they would have requested consultant assistance or made referrals.

Records of the observation and consultation conducted by the Guidance Center Consultants were kept in triplicate--one copy by the Special Needs Coordinator, one by the consultant, and the remaining one at the individual centers. The observation form described the activities observed or in which the consultant participated, the adults present, the classroom environment, along with additional child-specific behavior information. Developed during the initial CFMH Project year by the Special Needs Coordinator, these were usually filed by center within the Head Start administrative offices.

Children's Services

In accordance with the guidelines for the primary prevention emphasis, no direct services were provided to children through the CFMH Project. Mental Health Consultants did have contact with classrooms during observation sessions, staff in-service, and parent training, most often to demonstrate intervention strategies and teaching methods. Other informal interactions between the Mental Health Providers and children frequently occurred to help the children become accustomed to the consultant's presence and thus minimize disruption.

V. Support System/Resources

One of the major objectives of the CFMH Project was to identify, mobilize, and utilize available resources to provide necessary primary prevention/supportive services to Head Start children and their families. The Mental Health Providers and the Special Needs Coordinators were charged with the responsibility of tying the project into

any existing service network within the S.C.O.P.E. tri-county catchment area.

As part of the social services component of the Head Start program, community resource directories for each county were published and distributed among parents and staff. These provided a comprehensive alphabetical and subject listing of various types of agencies, professionals, mental health and medical facilities, with a concise description of their location, the services provided, and cost of services.

The Social Services and Special Needs Coordinators, when asked to identify those agencies with which the Head Start shared a close working relationship, mentioned several agencies in addition to the Guidance Center. Only two of these resources, WIC (Women, Infants, and Children) and the Division of Youth and Family Services, provided child-oriented or preventive services. Both, however, were primarily concerned with health and welfare, rather than mental health services.

Essentially, the Cumberland County Guidance Center remained the only agency in the area to provide mental health services to children, parents, and families. Along with the psychiatric, psychological, social work, occupational and socialization therapy, the Center also provided diagnostic, evaluation and treatment services. Thus, to a large extent, outside of consultation and education activities, the Guidance Center was not specifically oriented toward primary prevention until its collaboration with the CFMH Project.

VI. Evaluation of the CFMH Project

As previously mentioned, only informal procedures for evaluating and monitoring the CFMH Project existed during the first and second year (Refer to section on Administration). Staff and parental evaluations were obtained by the Special Needs Coordinator through brief surveys and the results conveyed to Head Start administrative staff, the Field Specialist, the HSAC, and Consultants. This data, plus other, more systematic program information, formed the basis for assessing general effectiveness, planning, and implementing project modifications.

The consensus echoed throughout interviews with the Head Start Director, Special Needs Coordinator, consultant, and teachers indicated that consultation and informal training were the most effective service available under the CFMH Project. All other areas, nevertheless, were rated as being useful and appropriate to the needs of staff and parents, as well as effective with both groups. All participants expressed general satisfaction with these roles, performances and the entire project's impact on staff, parents, and children.

Although the CFMH Project overall was seen as effective, the Head Start staff and consultant did, however, identify areas in which they

felt improvement was necessary to enable the project to run at peak effectiveness. For example, greater involvement with, and utilization of available community resources through joint public services activities and participation in an interagency council were suggested by the consultant as strategies to improve coordination with outside agencies. Internally, the integration of activities between the various component areas (formal staff in-service training, in particular) was seen as requiring greater attention in the upcoming year.

In assessing the project's successes, respondents tended to focus on the positive attitudinal changes exhibited by both parents and staff. Both groups also demonstrated an increased acceptance of the Mental Health Consultants. Thus, interpersonal relationships among staff, parents, and children noticeably improved as a result of the increased communication, self-confidence, and psychological support resultant from exposure to the CFMH Project.

Chester, Pennsylvania (Control)

I. Demographic Characteristic of the Community and Head Start Program

Citizens for Acting Now (C.A.N.), the community action program which serves as grantee for the Head Start program, has as its catchment area the 184 square mile Delaware County region. Located no more than 25 miles from the greater Philadelphia metropolitan area, Delaware County has a total population of over six hundred-thousand. Ninety-two percent (92%) of this population is White, 7% is Black, and the remaining 1% Puerto Rican and other ethnic groups.

Delaware County is comprised of several urban communities. A particularly densely populated area, its density in the county is approximately 3,201 persons per square mile. The median size of households in the area, according to the 1970 census, is 3.25.

The economic and social data for Delaware County depart from trends generally seen in similar urban areas. Unemployment is an exceptionally low 2.8%. The median family income is $11,822. Of 151,420 families in the region, only 4.6% of these have incomes below the poverty level, compared to 6.3% for the total county population. The median educational levels of the populace are 12.4 and 12.2 years for males and female, respectively. The drop-out rate among teenagers in the county is approximately four percent (4%).

However, these figures, particularly since almost ten years old, belie the true conditions existent in portions of Delaware County. Chester, for example, contains many physically and economically depressed areas, often characterized by substandard or abandoned housing structures. Though experiencing new growth and development, many sections of communities in Delaware county, nevertheless, have suffered urban blight.

The C.A.N. Head Start administrative offices, like many of the program's centers, are housed in a neighborhood church located centrally in Chester, Pennsylvania. Occupying two office spaces on the church's upper floor--a large open area used by the coordinators and another smaller office for the director--and a classroom downstairs, the Head Start program shares the facilities with another program from C.A.N.

Two hundred and seventy children and their families from the greater Chester area were served by the 23 centers in the C.A.N. Head Start program in 1978-79. One hundred and thirty-six of these children attended classes part-day (8:30 - 12:00 or 12:30 - 4:30) at the majority of the centers. The remaining 134 children participated in full-day sessions conducted at the two Head Start centers. The 24 classes at the C.A.N. centers generally operated nine months during the year, from September to the end of May.

II. History and CFMH Participation

The C.A.N. Head Start primarily became interested in obtaining a grant and participating in the CFMH Project as a result of a long-standing interest in providing comprehensive mental health services to Head Start children and their families. The Head Start staff, believing that the mental health component may have been one of the least strong areas in their program, begin intensive planning and development of a primary preventive program. After eliciting input from mental health agencies in the community, the program submitted a proposal in June 1977 requesting funding to implement the Mental Health Worker model of the Child and Family Mental Health Project. Based upon the program's assessment of community needs and the lack of appropriate resources to provide preventive mental health services to the Head Start program, the staff felt that this model would be the most effective delivery strategy.

The C.A.N. Head Start was not selected to operate as an experimental model. However, the program received funds ($1,800) to participate in the ACYF demonstration project as a control during the 1977-78 year. Since no costs were incurred during the CFMH controls during year one, initial project funds were carried and no additional funds were dispersed during the second year.

During 1977-78, the Head Start program experienced major expansions. Originally serving 224 children through thirteen centers in Chester and surrounding communities, the program opened ten more centers in local churches and community centers.

III. Project Structure, Administration and Coordination

The mental health component with the C.A.N. Head Start program is principally implemented by the Health/Mental Health Coordinator and the full-time staff Mental Health Professional. Hired in 1977, the coordinator, responsible mainly for administrative matters related to the mental health component, maintained records of developmental, psychological, and regular observational assessments along with health information on each child. He also assisted in planning and monitoring mental health activities and services. As in most Head Start programs, fiscal matters related to the mental health component, maintained records of developmental, psychological, and regular observational assessments along with health information on each child. He also assisted in planning and monitoring mental health activities and services. As in most Head Start programs, fiscal matters related to the mental health component were handled by the Program Director.

The staff Mental Health Professional, a psychologist hired in September 1978, undertook major responsibility for all direct mental health activities and services. The activities most emphasized during 1977

-78 included conducting parent education and training sessions, providing consultation to staff, child referral, teacher training in behavior management, and observing classrooms. Administrative tasks, program planning, and record-keeping also occupied a significant portion of the consultant's time during an average month. Yet, only a minimal amount of general staff training, crisis counseling, and treatment for children is provided through the mental health component.

Some of the functions performed by the Mental Health Consultant were not specifically stipulated within the mental health component. For example, during observation/consultation sessions, the consultant sometimes found it necessary to intervene with staff, helping them to resolve personal concerns or interpersonal conflicts which might interfere with their work in the classroom.

Since service coordinators generally have daily contact with each other, no formal procedures for coordinating the various component in the C.A.N. program have been developed. Regular staff meetings are held frequently throughout the month to discuss Head Start services, activities, and administrative issues. Additional special meetings between coordinators and the Mental Health Consultants were called when warranted.

Certain activities, particularly those in the areas of education and health, were considered by staff to be directly related to mental health and primary prevention though not expressly designed as such. Teacher training sessions, materials, and curriculum developed for the education component often focused on issues like behavior, management, or normal child development. Similarly, activities in health and nutrition naturally led to discussions on their relationship to a child's well-being. In some instances, the Mental Health Consultant might work with a component coordinator to incorporate mental health principles and concepts into a training session or presentation. However, no activities during the 1978-79 year were jointly implemented by the Mental Health Consultant and Service Coordinators.

IV. Major Goals, Objectives and Activities of the Mental Health Component

In most control programs, the mental health activities and services set forth in the Performance Standards formed the core of the program's mental health component. These were supplemented with further input from the administrative and center staff, parents, and the Policy Council. In addition, staff at the C.A.N. Head Start held the philosophy that a child should be viewed "as a whole person," along with other factors which contribute to his/her growth and development. Thus, they set goals and objectives, designed strategies, and implemented activities which embodied this concept.

Parent Education and Training

The consultant's work with parents regarding child issues; for example, normal growth and development and behavior management; was greatly emphasized within the mental health component. Approximately thirty-two hours monthly were devoted to conducting parent-oriented activities at each center in the program. No formal parent training was held during 1978-79, though the staff hoped to provide this in the upcoming year.

Intervention and Crisis Counseling

Crisis counseling and special intervention services were not directly available through the C.A.N. Head Start. In most instances, if families or parents required special assistance, the Social Services Coordinator would refer them to appropriate agencies. The Head Start staff, whenever possible, acted as an advocate for families by:

1. Serving as a liaison with resource agencies;

2. Providing transportation and any needed support; and

3. Insuring that the services provided were appropriate and promptly received.

According to the Social Services Coordinator, parents sought counseling or assistance with problems around their relationships with children, child abuse and neglect, interpersonal conflicts with other parents, or their spousal relationships. Various strategies for intervening or providing support to parents were available. For example, to involve parents who would not be receptive to either group or individual counseling, educational sessions might include discussions relevant to their concerns or problems. Some situations were resolved through simply actively listening and talking with the individual. Finally, when appropriate, senior college students from nearby West Chester State College were assigned to work with families on a monthly basis.

Staff Education and Training

Orientation and in-service training were conducted jointly for teachers, supportive staff, and aides from all centers. The orientation, which occurred during the first months of the program, consisted of workshops on communication skills, identifying and utilizing resources, and an overview of available mental health and handicapped services. In-service training, most often presented as part of the Handicapped, Education, or Social Services components focused on behavior such as language development, management, the classroom environment, and working with hyperactive children. Topics were generally selected by Service Coordinators in response to needs expressed by teachers.

Observation and Staff Consultation

An estimated 60% of the Mental Health Professional's time was spent conducting weekly classroom observations at one of the twenty-three centers providing follow-up consultation to teaching staff.

Observations generally focused on:

1. The room arrangement and classroom atmosphere;

2. Content of lesson plan;

3. Children with special needs; and

4. Indicators of the children's emotional, social and cognitive development.

Usually (i.e., at least 80% of the time, according to the Mental Health Professional), center staff initiated consultations through their requests. At other times, consultation sessions arose from situations observed during home or site visits. Common topics covered during the sessions focused on disruptive or negative behaviour, limit-setting, appreciation of the children's individuality, and procedures for obtaining mental health services. Curriculum input and practical guidance about promoting positive mental health through classroom activities were additionally provided by the consultant during follow-up.

Direct Services to Children

In general, all children in the C.A.N. Head Start program received psychological and developmental screening and diagnosis through the state-funded Intermediate Unit. However, the program had an additional strategy for serving children with special needs--those with learning disabilities, developmental lags, and physical impairments or handicaps. The Child Developmental Team (CDT) system was designed to assist parents and teachers in working more effectively rather than focusing upon their weaknesses.

In mid-summer during registration, medical information, family history, and information about suspected or actual handicaps are obtained for each child from parents. Throughout the year, teachers made observations of these children and held parent/teacher conferences to develop and reinforce strategies for the child. Referral forms containing a summary of teacher observations are next submitted to the Social Services and Education Coordinators. They, in turn, observe the child to validate the assessment, make referrals, and schedule appointments with appropriate agencies for complete diagnosis and/or treatment.

Consultants from these agencies generally observe children for a two-week period. A conference is then held with the program's Mental Health Coordinator and consultant, the agency consultant, the Education and Social Services Coordinator, and the children's teacher to discuss the diagnosis and develop an Individual Educational Plan (IEP). Finally, parents are again made aware of diagnosis results and involved in the development of their child's IEP.

V. Program Resources and Support System

Mental health services in the C.A.N. Head Start program were made possible through funds from the Health and Handicapped Services budgets. Additionally, in-kind services were provided to the program by various community and state mental health agencies and professionals. The following agencies, with which the C.A.N. program had developed strong working relationships, consistently provided services to Head Start children and their families:

1. Catholic Social Services - A multi-service, family-oriented agency, the Chester offices provided short and long-term counseling; information and referral services; crisis intervention; bilingual services and activities.

2. Child and Youth Services - With offices located in Chester and Upper Darby, casework services; short and long-term foster care; protective services for abused/neglected children; and day care for children 0-6 were provided for residents of Delaware County.

3. Community Life Services (Base Service Unit II) - One of four units in the county mandated by the state to serve children with special needs. Base Service Unit II often participated in the Child Development Team at the C.A.N. Head Start. Its principal services included evaluation, diagnosis, treatment of mental health, retardation, and substance abuse problems for children and adults on an out-patient basis.

4. Crozer-Chester Medical Center (Base Service Unit IV) - 24-hour crisis service; diagnostic evaluations; group, individual, and family counseling; and educational services were available on both in- and out-patient basis.

5. Family and Community Service of Delaware County - Created to serve families and individuals in need, the Family and Community Service provides casework, group treatment and conduct on outreach program.

6. Family Support Center - A relatively new agency, which focuses on preventing child abuse and providing support to the handicapped and their families. The Family Support Center has begun

to develop a good working relationship with Head Start.

7. Life Guidance Services - Another Base Service Unit, this agency in Broomall, Pa. provides similar services to those in the cities of Darby and Chester.

These and other agencies were listed, along with procedures and fees for utilization of services, in a resource directory available to parents and staff at all centers.

Despite the fact that many health resources exist in Delaware County, the Head Start staff expressed concern that none of them provided preventive mental health services. Also, because there was little communication or coordination among agencies, there was often a great overlap of services and duplication of efforts. Finally, as suggested by the mental health professional on staff, primary prevention, though an area worthy of greater attention, was nonetheless still an ideal rather than a goal for the C.A.N. Head Start at the present time.

VI. Evaluation of Health Component

The staff, as a whole, seemed satisfied with the services and activities provided under the mental health component. All felt that the training sessions and observation/consultations were effective and appropriate to the needs of staff and parents.

The implementation of the mental health services and activities during 1978-79 effected many positive changes among parents, staff and children. First, parents seemed to have greater trust and confidence in the program overall. This was particularly important to staff, who expressed much concern over the lack of parent involvement. Next, the staff developed greater awareness of children's needs and showed increased consistency and proficiency in working with their classes. In addition, as a result of the Mental Health Professional's interactions with staff, two significant things occurred: (a) intrastaff communication and relations improved and (b) teachers were provided with a much needed system of personal and professional support. Finally, children reaped the benefits of having caregivers equipped with better teaching, parenting, communication, and intervention skills.

Decatur, Georgia (Control)

I. Demographic Characteristics of the Community and Head Start Program

The Trinity Head Start Center in Decatur, Georgia is located in a rural area approximately 10 miles outside of Atlanta, Georgia. Decatur's total population numbers 21,943 with a total of 5,381 families. Of that population, 16.3% (or 10.5% of the total number of families) have incomes below the poverty level. The median family income is $9,663 with 5.9% of the population being unemployed. Also, Decatur boasts a large Black population with 8,650 or 40% of the population being Black and 13,256 or 50% being White.

The Decatur Head Start program funded for $147,650, operates out of one center which houses five Head Start classes. The center operates five days a week, from 9 a.m. to 3 p.m., from September to May. There is one teacher and one aide per class. Each class contains only children of the same age. Thus two classes have a total of 29 three-year-olds, one class has 20 four-year-olds and two classes have a total of 37 five-year-olds. Some kindergarten-age children are included in the five-year-old classes. Eighty-six children are serviced by this program. Ninety-one percent of the children, 100% of the teachers and 80% of the aides are Black. The remaining children are White (7 out of 86) while the only non-Black teaching staff person is an aide from Costa Rica.

According to their CFMH grant proposal, 75% of the families in the area are welfare recipients and one-parent families. The center is centrally located in an area of low-income housing which houses approximately 388 families, including approximately 150 preschool children. The community is described as being "dominated by physical illenss, domestic problems, alcoholism and drug abuse," with families being frequently under stress. Reportedly, many people in the area are unaware of the community services that are available to them or they do not utilize the services because of their fears and/or misconceptions about them.

II. History and Start-up of CFMH Project

The CFMH Proposal from the Decatur Head Start program was the result of the collective efforts of the Head Start Director, the Mental Health Coordinator, a local mental health agency, the Head Start Parent Policy Board, and the Head Start Board of Directors. Although it was a control project and thus should have had no "start-up" problems, the Decatur Head Start staff expressed concern about not receiving formal notification from ACYF as to their control status. The program received a $1,000 allocation for record-keeping in 1977-78, yet did not spend any of these funds. Reportedly, the funds had not been utilized because staff had not been formally notified of funding by ACYF and was unable to obtain guidelines for the expendi-

ture of their monies.

III. Project Structure, Administration and Coordination

The mental health component of the Decatur Head Start program was the responsibility of the Health/Handicapped Coordinator, whose qualifications include a Master's Degree in early childhood education and special education as well as various related work experiences. Although no specific budget allocation was made for mental health, the Health/Handicapped Coordinator spent approximately 3 hours per week on mental health activities within the program. Her responsibilities included the first assessment of the children, making referrals, getting parent consent forms signed, transporting children to agencies for direct services, arranging workshops, doing classroom observations and consultations, being sure mental health recommendations were followed through, making home visits, responding to referrals from teachers, and getting special equipment. She was also responsible for overseeing the work of three Mental Health Consultants. Two of these were in psychology and worked 4 hours per month. The other consultant, who was in education, was utilized on an as-needed basis. All consultants were reimbursed via Head Start funds, in-kind contributions, or donations by other agencies.

The Health/Handicapped Coordinator had numerous duties outside the mental health arena. Some of these are touched upon in the above listing of responsibilities. In fact, it should be recognized that as a full-time employee, the vast majority of her time was spent on non-mental health duties.

IV. Major Goals, Objectives, and Activities of Mental Health Component

As a control site, the Decatur Head Start program did not have special CFMH goals and objectives. However, this Head Start program did have a mental health component involving screening and diagnostic evaluation, therapy for children, and mental health education and training for staff and parents. Also, despite the fact that they did not receive CFMH funds to operate an experimental project, staff did manage to implement parts of their proposal (i.e., screening and diagnostic services and some workshops for staff and parents). Thus, the Decatur program's mental health activities for the year included:

1. Two staff orientation sessions lasting a total of 2 hours and serving 13 staff;

2. Two 1-1/2 hour staff training sessions which served 11 staff;

3. Four staff consultations with 5 staff (including one administrator);

4. Five 20-30 minute classroom observations;

5. One support or follow-up consultation (lasting 1/2 hour);

6. Eight instances of curriculum input to staff and administrators;

7. One half-hour parent orientation session;

8. One 1/2 hour parent training session (16 parents serviced);

9. Four referrals of parents; and

10. Three referrals of children.

Services to children included developmental screening of children by the Mental Health Coordinator as well as psychological assessment by Mental Health Consultants. Thus, the status of this program's activities, as compared to the "mandated" services for CFMH Project, can be summarized as follows:

1. Orientation for Staff and Parents - Service offered, but limited to one session.

2. Staff Training, Child Observations and Consultations - Services offered, but limited in duration.

3. Parent Training and Crisis Counseling Services - Services offered, but limited to one training session. Crisis counseling, referrals and assessments.

V. Support System/Resources

The Decatur Head Start program utilized the resources of several mental health agencies in their response to the mental health needs of the Head Start staff, parents and children. Since few resources existed in the immediate vicinity, staff had to extend their efforts to more distant areas to obtain the needed support. Thus, they had been able to utilize the resources of several agencies in the greater Atlanta Metropolitan Area. These included the Central DeKalb Children's Center, the Developmental Evaluation Counseling Center, as well as the services of a clinical psychologist. In addition, the families of the program utilized several non-traditional resources, including clergy, family and friends, and public health nurses.

VI. Evaluation

The mental health component of the Decatur Head Start program was viewed as being generally effective but lacking sufficient resources (monies, personnel, etc.) to do the kind of job that could be done in this area. The Head Start Director felt the mental health component was lacking sufficient staff, consultants, materials and supplies, equipment and space. She felt the program could offer

adequate mental health services to their population with the assistance of the existing network of agencies and mental health professionals, if they had adequate funds to support such activities. The teacher that was interviewed also expressed a concern that more funds be made available to support much needed mental health services. She felt the available services were insufficient, although she acknowledged that the Mental Health Consultants and staff were available for consultation at convenient times. Her criticism seemed more of the need to put greater emphasis on mental health than out of some negative evaluation of services offered. Finally, the Mental Health Coordinator also expressed awareness of the need for more resources. She specifically felt the need for a Mental Health Coordinator whose primary duties were in mental health. She expressed greater satisfaction with their services to staff and teachers though she felt they were only partially effective in their work with parents.

Galveston, Texas (Control)

I. Demographic Characteristics of the Community and Head Start Program

The Head Start program in Galveston, Texas is located on an island in South Texas, about 45 miles from the metropolitan area of Houston, Texas. The population of Galveston County is 169,812 within a land area of 299 square miles. Approximately 23,535 or 12% of the residents are below poverty line. The ethnic composition of the area is 33,314 Blacks; 135,481 Whites; and 1,118 persons from other ethnic groups. The median family income is $9,778 and the rate of unemployment is 3.7%. The median educational level for the population is 11.5 years.

The grantee organization for the local Head Start program is the Galveston County Community Action Council. The program, however, is delegated to the Central Day Care Association of Galveston. The program budget for 1978-79 was $383,701.36 and there are three separate centers--the Ziegler Head Start Center in Galveston, the Mainland Head Start Center in Texas City, and the Dickinson Head Start Center in Dickinson. The program serves 205 children. There are 141 Black, 36 Mexican, and 28 Caucasian children attending in the 1978-79 program year.

II. History and Participation with the CFMH Project

The Galveston County program received information about the availability of monies from the experimental Child and Family Mental Health Project in the Spring of 1977. Utilizing the expertise of the Head Start Director, the Mental Health Consultants, representatives of the Parent Policy Council, and the Board of Directors in developing and writing the proposal, the Galveston County Head Start program submitted a grant proposal in July 1977. Since there is no mental health budget, the principal objective in applying for the CFMH Project was to secure mental health resources that could be employed on a day-to-day basis and thereby insure more continuity of the mental health program.

Although the Head Start program was not funded for the experimental project, it followed through with the prior agreement that if it were not selected as an experimental project, it would serve as a control group. Therefore, the program received $1,800 from ACYF in 1977 for record-keeping and other activities related to serving as a control group. However, since the monies were unspent during the 1977-78 year, they were carried into the 1978-79 program years.

III. Project Structure, Administration and Coordination

There was no budget for mental health, so all personnel volunteered their time. The mental health component was implemented by the Mental Health Coordinator, who also served as a Mental Health Consultant, three other Mental Health Consultants, and a graduate student in social work who served as a child advocate. The other Mental Health Consultants spent approximately a total of 26 hours per month related to mental health activities. The Child Advocate devoted about 30 hours per week to community-oriented and mental health activities.

The Mental Health Coordinator had served in that capacity since 1975. A faculty member at the University of Texas Medical Center, she volunteered her time for mental health services at Head Start 8 hours per month. Her primary activities were to serve as a chairperson of the Health Services Advisory Council. In that role, she had a major responsibility in the planning of the overall mental health program for Head Start. She also was available to consult with Head Start staff and the Center Director on an as-needed basis. Finally, the Mental Health Coordinator served as a liaison and in a supervisory function for graduate students. According to the Head Start Director, the present Mental Health Coordinator was selected to fill that role due to her academic training and background in children and youth programs, her availability for in-kind services, and her institutional affiliation with the medical center.

Although the Head Start Director had the overall responsibility for all programs and activities, the operations of the mental health component were the responsibility of the Mental Health Coordinator. Mental health activities were coordinated with the various service components through the monthly Health Services Advisory meeting and meeting with other Service Coordinators as needed.

Record-keeping was the joint responsibility of the Educational Supervisor and the Mental Health Coordinator. That is, records of contacts between the Mental Health Consultants and Head Start such as in-service training and consultation were maintained by the educational supervisor, while records of direct work with children and parents were kept by the Mental Health Coordinator.

IV. Major Goals, Objectives and Activities of the Mental Health Component

The major goals of the mental health services of the health component were:

1. To develop standard primary prevention mental health services for day-care children and their families;

2. To identify and work with any members of community support systems; and

3. To identify and strengthen network support systems for at-risk families and to support healthy families in their use of community network support systems.

The more specific program objectives were:

1. To provide the staff, parents, and Community Care Coordinators with increased knowledge, understanding, and skills in the areas of normal human growth and development and predictable life crises.

2. To provide the staff, parents, and Community Care Coordinators with information about spontaneous support systems and community institutions and to help them maximize effective access to these systems in order to heighten their efficiency in dealing with the normal and unusual crises of life.

3. To identify those at-risk families who are not making use of their natural social networks and help them to effectively use these networks.

4. To identify the social networks and support systems of all day care families and work with them in the areas of utilization and characteristics of the networks and systems available to them.

5. To select and consult with Community Care Coordinators as key individuals in neighborhood networks and systems.

According to the Mental Health Coordinator, a range of mental health services were provided including developmental screening, parent-staff conferences, mental health consultation and education, etc. However, although precise statistics were unavailable, the primary service emphasis was developmental screening and mental health consultation and education to staff.

Orientation of Staff and Parents

At the beginning of the program year, an orientation to the mental health activities was conducted at each of the three centers to explain the objectives and plans for the year. This orientation for staff took approximately one-half to one hour at each of the three Head Start centers. There was no formal orientation for parents by the Mental Health Consultants.

Staff Training, Consultation and Classroom Observations

The total time spent by the Mental Health Consultants on a weekly basis was estimated to be two hours per week for the program year, totaling approximately 144 hours. However, this estimate did not include the amount of time spent by the child advocate in those activities, for the Mental Health Coordinator was unaware of the exact breakdown of those activities. Of the 144 hours spent by the Mental Health Consultant, however, an estimated 60% or 86.4 hours were spent in consultation with staff. Approximately 40% or 57.6 hours were spent in in-service training. According to the Mental Health Coordinator, the case-oriented consultation was conducted weekly or bi-weekly. The number of participants averaged about four, although the exact number was dependent on personnel involved with the child around which the case conference was focused. Finally, the formal in-service training workshops focused on broad issues such as child management and discipline, home visits and interviewing parents, observational assessment procedures and guidelines, identification of handicapped children, family dynamics and patterns.

Child observation by the Mental Health Consultants occurred on an as-needed basis. No precise figure as to the number of observations conducted during the 1978-79 program year were available.

Parent Training and Crisis Counseling

Parent training was conducted on a limited and informal basis. Therefore, no data as to its nature, the number of contacts, or the number of recipients was kept by program staff.

Services to Children

The Head Start program did not provide any formal diagnostic or treatment services to children or families, except for an initial screening. All children that were identified as needing direct mental health services were referred to outside agencies. The mental health screening involved administering a happiness scale that compared each child with every other child in the class. Data from this initial screening was used to determine what, if any, follow-up is needed.

V. Support System/Resources

The Head Start program utilized a variety of agencies and community facilities including the Pediatrics Department of the University of Texas Medical Branch, the State Department of Mental Health and Mental Retardation, the Public School System and the Children Council. However, despite the usefulness of these agencies, they were limited, according to Head Start staff, by their own service priorities and, therefore, were not available to Head Start for a substantial amount of time on an ongoing basis.

VI. Evaluation

The Head Start Director and the Mental Health Coordinator concurred that the available mental health services were effective, particularly with teachers. However, both agreed that mental health activities were severely limited by the absence of any funds for mental health services. The most effective of the existing services, as rated by the Mental Health Coordinator, was the early identification and intervention thrust, utilizing referrals to community agencies. The principal limitation was the absence of a mental health person on a regular basis. There was a particular need expressed by staff for more case and program consultation.

Hughesville, Maryland (Control)

I. Demographic Characteristics of the Community and Head Start Program

Located approximately 60 miles southeast of Washington, D.C. the Tri-County Head Start program, with its administrative offices located in Hughesville, Maryland, operates in the southern peninsula counties of Calvert, Charles, and St. Mary's. Various small cities and towns (La Plata, Hughesville, Waldorf, Leonardtown, and Prince Fredrick) are interspersed throughout the 1,049 square-mile region. The total population for the three counties is slightly above 122,000. St. Mary's and Charles Counties have populations nearly twice that of Calvert.

The major industries within the tri-county area consist of nuclear and electrical power facilities. Unemployment rates (based upon the 1970 Census) vary across the counties, with Calvert having the highest at 7.4%. In Charles and St. Mary's Counties, the figures are 3.7% and 4.3% respectively.

These conservative figures, however, reflect only a portion of the total socioeconomic picture for the area. Despite the fact that the unemployment rates for the southern Maryland counties are not particularly severe, approximately 30% of the population here lives in poverty. The median family incomes within the tri-county region range from $8,267 (St. Mary's) to $10,377 (Charles). The average number of families existing in poverty is 1,072.

A surprisingly high proportion of these families are female-headed: 61% in St. Mary's County, 69% in Calvert, and 92% in Charles. Such families constitute over half of the poor families in southern Maryland. According to their grant proposal, other significant socioeconomic problems (crime, substance abuse, inadequate and substandard housing, low educational achievement, etc.) abound in the tri-county service area. These are additionally compounded by the political and social apathy of the residents.

These facts, along with the data from more recent assessments conducted by the Social Services Coordinator and Mental Health Consultant, suggest that the services provided through Head Start address the needs of the southern peninsula communities. Particularly, since comprehensive services are available at the tri-county program, it plays an important role in the welfare of its participants.

The Southern Maryland Tri-County Community Action Committee, a social service agency and grantee for Head Start, operates several other programs for children, youth, families and the elderly. Two hundred and seventeen children, aged 3-5, attend the five centers in Brooks, McCouchie, Indian Head, Levington Park, and Randle Cliff. These centers conduct part-day sessions during the year. Another

139 children are served through a home-based program--visited by a family worker weekly, and brought in monthly for a center-based classroom experience. Although Blacks comprise only 24% of the total population in southern Maryland, over 90% of the children enrolled in the Head Start are Black.

II. History and Start-Up

In applying for CFMH funding, the Tri-County Head Start expressed a special interest in extending its ongoing efforts to affect the mental well-being of children through parent education activities. Few start-up problems related to staffing were anticipated because the Head Start staff and Health Services Advisory Committee members had candidates in mind for the positions of Mental Health Worker (MHW) and Mental Health Supervisor at the time of proposal development. Moreover, because the MHW candidate was to be selected from the program's parent education component, no problem was anticipated in attempting to integrate CFMH activities with ongoing mental health preventive activities which were already underway.

Although not selected as an experimental program, the Tri-County did receive $2,000 to participate in the CFMH demonstration effort as a control program.

III. Program Structure, Administration and Coordination

The Mental Health Consultant for the Hughesville program, though employed only part-time, also served as the Coordinator of the mental health component. The consultant, who began working with Head Start in November of 1978, contracted to provide consultation, training, and administrative planning sessions to administrators, teaching staff, and parents. He additionally was responsible for reports on all mental health activities and for developing any necessary training and service reports forms or materials.

Spending an average of 24-32 hours monthly, the consultant:

1. Observed children at the seven centers;

2. Identified children with special needs;

3. Worked with staff in facilitating staff-child relations;

4. Conducted staff and parent training in child development, stress, etc.;

5. Planned and implemented the mental health plan; and

6. Consulted with staff and discussed their concerns.

IV. Major Goals and Activities in Mental Health

Although joining the Hughesville program in November of 1978, the Mental Health Consultant nevertheless developed and implemented a complete plan of services and activities by early December of that year. Working closely with the Head Start Director and the Health Coordinator, the Mental Health Coordinator participated in administrative planning sessions designed to organize the implementation of the program's mental health delivery system. A schedule of activities which would facilitate positive mental health was developed and approved by the Head Start Director. Planning meetings involving the Health and Mental Health Coordinators and the Mental Health Consultant continued on a monthly basis.

By mid-November, the first of the monthly newsletters containing various articles on mental health, child development, discipline, instructional activities for the home, and program or local center news was distributed to parents. Staff orientation and training sessions were conducted in December and January. During the first week of the new year (1979), the consultant began visiting centers to conduct observations, consult with teachers, and run parent training workshops. Generally, each month's activities consisted of observation/consultation visits and follow-up to two centers, a regular parent-staff sharing session, or another special activity.

Staff Training

Three training sessions to orient and educate staff about general child development issues and to assist staff in working more effectively with Head Start children were held during the year. These sessions additionally focused on providing teachers and aides with specific pedagogic techniques and intervention strategies to employ within their classrooms. By helping staff to manage daily situations, as well as recognize and cope with other life stresses, they became more confident and effective in their interaction with children, parents, and each other.

Parent Training

Parent training sessions, which often took the form of topical group and panel discussions or family-oriented activities, occurred monthly. These sessions were also used to elicit parental input for the mental health plan to obtain feedback about the appropriateness and effectiveness of current activities. Films, literature, and other materials developed or selected by the consultant were usually available to parents at these meetings.

Observation and Consultation

Observation and consultation were conducted at all centers in the Tri-County Head Start program. During site visits, the consultant

typically observed children and staff engaging in normal classroom activities, focusing particularly on the nature and quality of their interactions, and on the environment as a whole. Afterwards, center staff and the consultants discussed the day's events, considering both teacher and consultant perception. Children requiring special attention, for example, those considered hyperactive, withdrawn, or aggressive, were identified. Special behavior management techniques and strategies for working with the children generally evolved from the case consultations. The effectiveness of the intervention was usually monitored through follow-up sessions with parents and/or staff.

Direct Services to Children, Families

The Mental Health Plan was developed by the Tri-County Head Start to promote mental well-being among the children and to address the special needs of particular children in the program. Under this plan, observations, consultation, training, home visits, and counseling provided to staff and parents served indirectly to accomplish these goals. However, some direct services, primarily developmental screening and psychological assessments, were also provided to children. In cases warranting more intensive mental health services, the Mental Health Consultant would generally identify an appropriate agency and refer the child to it.

Similarly, when parents or families in the program were identified as needing assistance or specifically requesting help beyond that available through Head Start, arrangements were made to secure the necessary help for them. In all cases, the consultant conducted follow-up to ensure that the services provided were prompt and appropriate. Additionally, a program resource directory containing information about available mental health services in the three counties was given to parents and staff during the year.

V. Support System/Resources

Within the three rural counties served by the Head Start program, few mental health facilities exist. Families in these areas, though similar to those of other Head Start programs in the respect that they were unwilling to seek mental health services when needed, additionally suffered because no adequate network existed. For these reasons, the tri-county program first submitted its original proposal to apply for funds to implement the Mental Health Worker model of the CPMH Project. The Tri-County Youth Services Bureau, a multi-service agency for children and youth located near Hughesville, was, for example, one of the few available resources in the region. Yet, this agency, like the others, offered mostly secondary or tertiary mental health services and had limited facilities for working with preschool children. Other agencies, perhaps better able to provide the needed services to Head Start staff, parents, and children, were located over 50 miles away in Baltimore and Washington, D.C. Thus, to render

effective mental health services of a preventive nature within this program, a network of resources would have to be expressly developed for that purpose.

VI. Evaluation

The Head Start administrators and the Mental Health Consultant developed a system of criteria to evaluate their mental health plan, which they call the DARE model, an acronym for durability, availability, reliability, and excitability. The plan was deemed to be durable because (a) though inclement conditions experienced during the winter caused certain changes in the schedule of activities and services, center staff and the consultant were able to get the plan back on schedule through diligence and skillful coordination of their time and efforts, and (b) consultant interactions with children, parents, and staff seemed to have a lasting impact. Information and service related to the mental health plan were readily available to staff and parents because of consultant and administrative accessibility. Based upon staff and parental feedback on the observation/consultation training workshop and other services, the plan was reliably implemented. Finally, the excitability factor was demonstrated by the overall enthusiasm generated about the consultant's performance and the implementation of the mental health component.

A more systematic evaluation of the components' impact was conducted by surveying parents and staff as to their needs, interests, and the match between these and the offered services. The responses were overwhelmingly positive. Only one area, according to staff, fell slightly short of their expectations--the identification, utilization and collaboration with viable mental health agencies with Calvert, Charles and St. Mary's Counties.

Indiana, Pennsylvania (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Indiana County Head Start, located approximately 60 miles northeast of Pittsburgh, Pennsylvania, serves over one hundred families throughout the 825 square-mile rural county. The principal economic functions within the county are coal mining and farming, with light industry and manufacturing companies interspersed in some areas. The employment rate for the county is a relatively low 4.5%

Out of the population of 79,451, approximately 15.8% of the individuals live in poverty. Slightly over one-tenth of all families in the region have incomes well below the established poverty levels. For the entire county the median family income equals only $7,947. Almost 2,000 families, just under 9% of the total number of families, are female-headed. Half of these are comprised of working mothers with preschool-age children.

In predominantly white Indiana County, minorities constitute only one percent of the total population. The median educational level for male population in the region is 11.4 years. For females, the median number of years in school was slightly higher at 12.1 years.

A non-profit corporation, the Indiana County Head Start currently operates four two-classroom centers in Blairsville, Commodore, Indiana, and McIntyre. Children, recruited from within a 10-mile radius of each center, attend the full year program Monday through Friday for a four-hour period. Until 1978, additional families in the southern end of the county participated weekly in the Home Visiting program and attended classroom-based experiences at one of the centers bi-monthly. These and other families now attend regular sessions at the recently opened Blairsville center.

Under a locally designed option, child enrollment at an Indiana County center was based upon mandatory parental involvement. Parents must volunteer to work in the classroom and kitchen for minimally two days per month.

Reflecting the ethnic composition of the communities served, the Head Start Centers are also predominantly White. Only two centers have minority children in attendance--1% at the first center and 3% at the other. All of the children in the program range in age from 3-to 5-years old. However, 4-year-olds comprise the majority of the classes, which contain, on the average, 15 children.

II. History and Start-up

During the initial year, the Indiana County Head Start received $15,400 to provide services to approximately 160 families and its staff through the Child and Family Mental Health Project. Prompted by existing needs of the parents and teachers in the program, the Head Start staff and consultants from the Indiana County Guidance Center collaborated in planning, developing, and implementing the project. The funding received thus brought to fruition the efforts of these two agencies, enabling them to expand upon a well-established, two-year relationship and to provide primary preventive mental health services, rather than secondary or tertiary ones.

The CFMH Project began in the Fall of 1977, experiencing no major start-up difficulties. Three psychologists from the Guidance Center, one of whom was the Executive Director of the agency, began working immediately with the program. Selected because of their interest and experience in providing consultation and education services to the Indiana program for the previous two years, these mental health professionals all had extensive teaching experience and training in family therapy.

Focusing on key issues related to primary prevention, family life, and child development, the Indiana County program set the following as its goals and objectives for the 1977-78 program year:

1. To develop an "ecological approach" to the Head Start Family Unit which will enhance positive mental health principles.

2. To develop skills in teachers and parents which foster children's social competency and positive social interactions.

3. To assist teaching staff in dealing with classroom behavioral problems.

4. To teach parents.

Head Start implemented various activities--staff education and training, parent training, and staff consultation--to achieve these goals and objectives. Evaluative procedures for each of the areas were also developed to internally monitor on-going project activities and to assess their effectiveness at year's end.

The first component of the CFMH Project, staff training, was designed to assist the teaching staff in developing pedagogic and behavioral management techniques which would contribute to the children's health, social and emotional development. Through participation in a series of bi-weekly workshops and sessions conducted by the consultants, teachers and aides received training which focused on acquisition of listening skills, utilization of assessment instruments, and understanding familial interactions. Audio-visual materials, speak-

ers, and other resource materials for training activities were obtained through the Guidance Center.

The first 10 out of 16 training sessions consisted of 3-hour workshops which covered basic concepts, principles, and techniques in behavior management. As part of the internal evaluation of the effectiveness of this stage of training, teaching staff participated in individual behavior-change projects which incorporated newly acquired skills.

Three sessions on listening skills particularly emphasized the importance of parent-staff communication. Role-playing and additional assignments were used to assist teachers and aides in mastering techniques for both active and passive listening, overcoming difficulties in interpersonal communication, and using these skills for effective problem-solving.

The remaining three education and training workshops covered principles related to development of competency in children and promotion of positive mental health. The topics addressed in assigned readings and group discussions during this last module included normal child development and ecological influences; age-appropriate behavior and readiness; and methods for helping children cope with typical life stresses.

Staff consultation during the 1977-78 year also occurred on a bi-weekly basis at designated centers. The regularly assigned mental health professionals and additional consultants from other resource agencies provided consultation to the 25-person teaching staff through 30 one-half-hour sessions.

Parent meetings, held monthly, served as the vehicle for educational and training activities. Parents and families were transported to all activities during the year by buses provided through contractual arrangement with the Rural Transportation Alliance. Activities under this component were principally designed to help parents acquire an understanding of child development, family life, and pertinent issues in mental health. In addition to instructional activities, other appropriate family activities--picnics, work projects, and recreational nights--were held to encourage positive interactions among the Head Start staff, parents, and children.

Finally, the CFMH Project provided for intervention and treatment services for 10-15 families in the Indiana County program. Though many of the services in this component were necessarily secondary or tertiary, the objectives still had a prevention emphasis:

1. To assist the family unit in developing strengths to aid in helping a troubled member.

2. To remediate, as quickly as possible, a problem within the family unit.

3. To develop strengths within the family to allow it to cope with similar problems in the future.

The administration of these services--record keeping, meetings, etc., --were handled jointly by the Head Start staff and Guidance Center Consultants.

Although the first phase (1977-78) of the CFMH Project was well-received and considered successful by participants, the project nonetheless encountered minor problems. Not surprisingly, during the first year, consultants and staff continually placed more emphasis on problems and "the problems approach," despite attempts by the Planning and Human Services Field Specialist to change this orientation. A lack of adequate project coordination and understanding of preventive mental health concepts and strategies among Head Start staff further contributed to the focus on secondary services. Finally, low parent attendance at CFMH activities resulted from the frequent scheduling of meetings and severe weather conditions during the late Fall. These problems were addressed, and to a large extent, resolved, by programmatic changes instituted during the following year.

In summarizing the CFMH Project's major successes for the 1977-78 year, the Head Start staff felt first that it enabled parents, staff, and the administration to talk about and handle difficulties before problems could develop. Secondly, by orienting parents to the concepts of positive mental health and prevention, the project had helped to eliminate misconceptions about mental health and related services. Third, the establishment of rapport between consultants, staff, and parents facilitated greater communication, sharing, and cooperation among them.

III. Project Structure, Administration, and Coordination

As during the first year, psychologists from the Guidance Center served as the mental health providers for the CFMH Project during 1979-80. However, by January of 1979, the entire staff of the project--the CFMH Coordinator and consultants--was different from that of the previous year. The two original consultants who had provided the bulk of observation and consultation to centers resigned within a four-month period beginning October 1978. The third consultant, the Guidance Center Executive Director, responsible for external administration, supervision, and coordination of the providers' activities, was also replaced when the mental health agency underwent a change in administrative staffing. Although this staff turnover unquestionably affected the project operation, the on-coming consultants quickly oriented to their new responsibilities, were soon well-accepted by Head Start staff and parents.

The Consultation and Education Specialists (consultants) worked with the CFMH Project on a part-time basis, devoting approximately 30 hours a month to the Indiana County program. In addition, the C&E Specialists donated almost 20% more time and services in excess of that for which the project contracted. The two consultants--a clinical psychologist and an educational psychologist--were assigned responsibility for specific sites, though they would occassionally conduct activities jointly.

Within Head Start, the program's Family Services Coordinator was designated to work with the CFMH Project in September 1978, replacing the Health/Handicapped Coordinator. As full-time staff person, the coordinator's responsibilities related to the CFMH Project included monitoring service delivery as specified by the contract with the Guidance Center; maintaining contact with consultants and center staff; and attending staff/parent training sessions. Thus, her involvement with CFMH activities required approximately 20% of the Family Services Coordinator's total program time during a given month.

The Head Start Director, though involved peripherally with the Child and Family Mental Health Project activities, handled primarily financial and administrative matters and monitored service delivery along with other staff members. Additionally, she was always available to consultants to provide assistance or address issues which might arise during the year. Though instrumental in the planning and development for the project each year, she nevertheless jointly shared all other functions with the Guidance Center Executive Director and the CFMH Coordinator.

The Head Start staff, despite its extreme pleasure with the performance of the consultants, conceded that there still were special problems associated with the use of consultants versus on-staff providers of mental health services. In particular, the process of bringing two agencies with dissimilar functions, orientations, and procedures together for a cooperative project required an enormous amount of effort, time, and compromise. In addition, the fact that consultants were only available on a part-time basis meant that they were sometimes unfamiliar with Head Start's philosophy or unable to handle occurring crises at the centers.

IV. Major Goals, Objectives, and Activities

The goals, objectives, and activities of the 1978-79 Child and Family Mental Health Project virtually remained the same as those for the preceding year. Certain programmatic changes, however, were instituted to resolve problem areas encountered during the first-year operations. In most components--orientation, parent education and training, and staff in-service training--these changes involved the reconceptualization of strategies and time sequences of service delivery.

Orientation for Staff and Parents

At the beginning of the year, orientation activities were held to acquaint parents, teaching staff, and administrators to the overall purpose of the CFMH Project. Particularly because the staff recognized that the emphasis of the project during its first year at times was not preventive, greater efforts were directed toward ensuring that all CFMH participants fully understood the nature of the activities and services. Written materials, films, and introductory sessions conducted by the Consultation and Education Specialists focused upon topics such as healthy social/emotional behavior, effective teaching techniques, and child-rearing practices which contribute to positive mental health.

Parent Education and Training

The Head Start staff and mental health consultants at the Indiana County program consistently emphasized the importance of providing children with experiences and environments conducive to the development of social competencies. By assisting parents in understanding the normal developmental processes children undergo and by identifying child-rearing techniques, attitudes, and ecological influences which promote a child's well-being, the program worked to accomplish one of its primary goals--to foster positive social, emotional, and cognitive development among Head Start children.

To address concerns regarding low parent participation in CFMH activities during the previous year, parent meetings were changed so that they occurred monthly rather than bi-weekly. Five such sessions were held at each of the program's four centers. Activities and discussions during parent meetings generally concentrated on the "well-child" concept, exploring various subjects in the areas of prevention, child development, and parent effectiveness.

Another area emphasized as part of the parent education and training component was concerned with family life--human development, family strengths, and common situations or stresses families experience, etc.

Discussions, brief lectures, group or family-oriented projects, and other more recreational activities were again incorporated to encourage families to interact more frequently and positively. Other topics of interest or concern to parents, ascertained through surveys administered at each center, were also included in the training unit. These subjects identified or selected by parents included divorce and separation; child abuse; childhood fears; and death and dying.

Various materials containing information relevant to all the areas covered in the training component were made available to parents throughout the year. A library of selected books, pamphlets, and articles was rotated among the centers in the program. Finally, the

consultants wrote a question and answer column and special articles to address particular concerns, interests, or problems parents had which were not touched upon during formal training sessions or consultations.

Attendance during the project's second year virtually did not change. However, it varied from center to center, ranging between 30% to 50%. So again the issue of increasing parent participation remained to be addressed in the upcoming year.

Intervention and Crisis Counseling

Two thousand dollars ($2,000) of the CFMH funds for the second year was available to provide crisis intervention and individual or family therapy through the Guidance Center to those requiring such services. The mental health providers were easily accessible to parents through both the Guidance Center and Head Start. Generally, the consultants remained at centers after each monthly parent training session to talk with individual parents about personal, family child-related concerns.

An estimated fifteen parents received counseling from the mental health professionals. Their concerns typically centered around marital problems, drug and alcohol abuse, or parent/child interactions (discipline, in particular).

Though the Guidance Center had the capabilities to handle screening, diagnosis, and counseling for children and adults, referrals might be made when families required assistance more appropriately provided by some other agency. No persons or families from any of the centers required such referral during the 1978-79 year.

However, most parents required only short-term counseling or, as stated by one of the consultants, "reflective listening" during one session lasting a half-hour to an hour. When appropriate, follow-up services were provided.

Staff Education and Training

Education and in-service training for teachers and aides consisted of a combination of classroom-based experiential activities as well as didactic group sessions. Held on a monthly basis, workshops conducted by the Guidance Center staff, covered key elements of child growth and development; use of assessment tools to monitor behavior and development; effective teaching strategies; and listening/interaction skills. Divided into nine 2-hour units conducted jointly for all center staff, the workshops additionally focused on areas of concern identified by teachers--the helping relationship, motivation, achievement, death and dying, etc.

Observation/Consultation with Staff

Over 120 hours of consultation time was provided by consultants during the CFMH Project's second year. The monthly consultation with teachers and aides was conducted on both an individual and group basis. In an attempt to move away from the problem/remediation orientation established by consultants in the previous year, up to 75% of the consultation provided under the CFMH Project occurred in group sessions. This strategy, according to staff and consultants, maximized the chances that the topics discussed would focus on primary prevention and be universally appropriate to total staff needs.

More specific case consultations (which occurred infrequently) were handled following center observations. After observing the entire class and teacher while engaged in different activities and taking note of particular children for whom staff requested special assistance, consultants would provide teachers with feedback during follow-up sessions. At this time, teachers received reinforcement on things done well, suggestions related to curriculum and recommendations for working more effectively with their class as a whole or with selected children. By engaging teachers or aides actively in discussions of their perceptions of the classroom environment, encouraging them to develop and utilize new behavior management and teaching techniques, consultants were able to work successfully with center staff.

Direct Services to Children

Direct mental health services, per se, were not provided by the CFMH Project. In particular instances when consultants noticed children within a center who required special assistance, they would refer them directly to the Guidance Center or some other appropriate agency for screening, diagnosis, or treatment. However, during the course of observation and informal in-service training, the Consultation and Education Specialists often interacted with children, engaging them in classroom activities or play, to become more familiar with them individually.

V. Support Services/Resources

The implementation of the CFMH Project met a critical need among the Indiana County Head Start families for mental health services, which were not remedial or secondary in nature. Before the receipt of these special funds, the majority of the program's mental health services were purchased out of Health or Handicapped monies. Other services, though only a minimal amount, were provided as in-kind by various community resources.

The Indiana County Guidance Center, located within a few minutes walking distance from the Head Start administrative office, was

considered as a viable resource for assisting the program in implementing its preventive mental health project. However, the Head Start staff believed that both agencies would have to continue working toward improving their relationship, developing procedures to increase coordination, and establishing a common framework for negotiating administrative issues.

Other key social and mental health agencies within Indiana County and adjoining areas comprise Head Start's resource network, providing supportive and specialized services to children and families. These agencies, identified by the Family Services Coordinator, are given below, along with a brief description of the services they offer:

1. Armstrong/Indiana Counties Intermediate Unit - Screening, diagnosis, and training for emotionally disturbed and handicapped students; and psychological and developmental services.

2. Child Study Center - Psychological testing; diagnostic assessment of behavior; and parent training in behavior management.

3. Child Welfare Services of Indiana County - Information clearinghouse; screening; referral; foster family and temporary care; services for abused children; adoptive and protective services; etc.[5]

4. Children's Hospital of Pittsburgh - Follow-up assessments; comprehensive services for socially, emotionally, and mentally disturbed children.

5. Connect - Information and referral services for families of handicapped children or those with educationally related problems; training materials and supplies on child-rearing problems and handicapping conditions.

6. Indiana County Community Action Program - Supportive services; community food and nutrition program.

7. Indiana Hospital - Medical, dental and psychiatric services.

8. Indiana University of Pennsylvania Psychological Services - Diagnostic and rehabilitative services provided by students under direction of members.

9. Mahoning Medical Center - Health services to families in the north end of Indiana County.

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[5]Frequently provide direct services; accept referrals from Head Start.

10. Open Door Crisis Center - General crisis intervention; short-term counseling; drug and alcohol abuse counseling; 24-hour hotline.

11. Parents Anonymous - Training for Head Start staff and parents; parent group; crisis intervention and childcare services; 24-hour Parent Hotline.

12. Speech and Hearing Clinic - Diagnostic evaluation; speech, hearing and language therapy.

VI. Evaluation of CFMH Project

As stated earlier, the CFMH Project Coordinator assumed major responsibility for monitoring and evaluating the activities, services, and performance of the mental health consultants. She attended all training sessions for both staff and parents, maintaining minutes and attendance sheets for each. She also visited centers during consultations, talked with staff and parents to obtain feedback about the project, and distributed more formal evaluation forms among CFMH participants to assess its effectiveness.

The Coordinator developed procedures to account for CFMH funds. All services performed and occurring activities were logged, along with associated cost data.

Considered by both staff and consultants to be effective overall, the CFMH Project had several major accomplishments for the 1978-79 year. Primary among these were self-confidence and competence fostered among teaching staff as a result of the consultation they received.

Equipped with various teaching, classroom management, and listening skills, teachers felt more capable and effective (1) working with all children, in general, (2) assisting children with special needs, and (3) involving parents in the children's education. Interstaff and staff-parent relationships were noted as having improved.

Parents also seemed to benefit from the Project's services and activities. From session to session, as one consultant responded during an interview, they became more open and involved. Parents began to know each other better, to share and learn from one another. Most learned a great deal about mental health services, prevention, and parenting.

At the year's end, the staff felt a few issues still existed which required additional attention to resolutions. Concerns were expressed about how best to "sell the program to parents," to increase parental involvement. Next, methods for more effectively integrating the project activities with those of the on-going program were also being addressed by the administrative staff.

Yet, perhaps most importantly, the staff continually focused on the need to improve relations with the new administration at the Guidance Center and to "iron out" long-standing difficulties (i.e., the issue of confidentiality vs. accountability when crisis counseling services were provided to parents) with the agency.

Kirksville, Missouri (Control)

I. Demographic Characteristics of the Community and Head Start Program

The Head Start program, operated by the Northeast Missouri Community Action Agency, is located in Kirksville, Missouri, which has a population of 15,944. The Head Start program is funded to serve the five (5) counties of Adair, Clark, Knox, Schuyler and Scotland. The population of the aforementioned counties are 22,472; 8,260; 5,692; 4,665 and 5,490; respectively. The median educational level, the unemployment rate, and the median family income are listed below by county:

County	Education	Unemployment	Income
Adair	12.1	5.0%	$6,861
Clark	11.2	6.9%	6,099
Knox	12.1	1.7%	5,981
Schuyler	11.9	5.2%	5,058
Scotland	11.2	2.4%	5,138

According to 1979 census data, the ethnic distribution may be characterized as almost exclusively white. Records show no Spanish-speaking residents in the five counties served, and a quite low Black population, ranging from a high of 186 in Adair County to one (1) Black in Schuyler County.

Currently, the Head Start program has a total budget of $273,560 and serves 128 children. Consistent with the ethnic distribution of the surrounding community, the children in the program are all White. The Head Start program in four (4) of the counties is center-based, in which the children attend the center four days a week and the fifth day is utilized for staff training, planning, and for home visits. The "home-based" model is employed in Knox County, where the families are spread throughout the county.

II. History and CFMH Participation with the CFMH Project

During the past few years, the Northeast Missouri Community Action Agency's Head Start program focused its mental health component toward screening children for psychiatric and psychological symptoms, conducting classroom observations and providing mental health consultation to staff and parents about problem children. Due to limited funds, the mental health program then primarily utilized secondary and tertiary prevention modalities rather than primary prevention. Thus, when the Head Start program was notified in the Spring of 1977, that the Administration on Children, Youth and Families was seeking proposals for the experimental CFMH Project, it submitted a grant proposal in order to expand and improve the quality of the mental health services. The participants in the process of

planning and developing the proposal included the Head Start Director, the Health/Handicap Coordinator, the Mental Health Consultant, representatives from the Parent Policy Council, and representatives of an outside agency.

Although the local Head Start program was not selected as a CFMH experimental project, it was awarded funds from ACYF to serve as a control group site. However, the Head Start program received only $500 of the $1,500 awarded in 1977-78, and since they received no instructions or guidelines as to how the money was to be spent, the funds were carried over into the 1978-79 year.

III. Project Structure, Administration and Coordination

The implementation of the mental health component within the Head Start program is the responsibility of the Mental Health Coordinator, the Mental Health Consultant, and graduate students from Northeast Missouri State University who are supervised by the Mental Health Consultant. Although the ultimate administrative responsibility for mental health services resides with the Head Start Director, the day-to-day coordination is the responsibility of the Mental Health Coordinator, who also serves as the Health Specialist/Handicap Coordinator. The Mental Health Coordinator is assigned to mental health activities for 10 hours per week. Her major activities are: (1) to serve as a liaison between Head Start staff and the Mental Health Consultant; (2) to plan and arrange for developmental screening and staff consultation; and (3) to participate in the developmental screening. Mental health activities are coordinated with the other service components through the weekly staff meetings and through Team C which is comprised of Head Start teachers from the other, central office staff, and the Head Start Director. Team C meets approximately once per month to discuss program goals, problems, and future plans.

The delivery of mental health services to children, families, and Head Start staff is the primary responsibility of the Psychological Consultant, who has a doctorate in school and counseling psychology. Chairman of the Department of Special Education at Northeast Missouri State University, the consultant is also a part-time private practitioner. Four masters-level graduate students in special education, supervised by the Psychological Consultant, provide developmental screening and direct interactions with children, particularly around speech and language issues.

IV. Major Goals, Objectives, Activities of the Mental Health Component

According to the Mental Health Plan, the objectives of the Mental Health Component of the Head Start program are to:

1. Assist all children participating in the program in emotional

cognitive, and social development toward the overall goal of social competence in coordination with the education program and other related component activities.

2. Provide handicapped children and children with special needs with the necessary mental health services which will ensure that the child and family achieve the full benefits of participation in the program.

3. Provide staff and parents with an understanding of child growth and development, an appreciation of individual differences, and the need for a supportive environment.

4. Provide for prevention, early identification, and early intervention in problems that interfere with a child's development.

5. Develop a positive attitude toward mental health services and a recognition of the contribution of psychology, medicine, social services, education, and other disciplines to the mental health program.

6. Mobilize community resources to serve children with problems that prevent them from coping with their environment.

According to the Mental Health Coordinator and the Mental Health Provider, the major service emphasis of the mental health component within health services is to provide early identification and intervention with children with emotional problems or "at risk" children. To a lesser extent, training and consultation were provided to staff.

Orientation for Staff and Parents

At the beginning of the year, the Psychological Consultant provided all staff with an introduction to the mental health component of Head Start. He informed the staff of the availability of mental health resources in the community and on his role as a consultant. He also explained to the staff the type of behaviors which indicate the need for psychological assistance, observation techniques, recording of observations, and confidentiality of mental health information about specific children. This orientation which was implemented in each county totalled 4 hours. At least 30 recipients attended the orientation. The Psychological Consultant also conducted a 2-hour orientation to the mental health component for parents.

Staff Training, Child Observations, and Consultation

The Mental Health Consultant trained Head Start staff through preservice and in-service training. Training needs were determined by center staff request, central staff requests, and training needs seen by the Mental Health Consultant. An 8-hour workshop was offered in December 1978 on staff relationships with parents (how to consult, confer, work with parents). The training was attended by 30 staff..

In conformity with Head Start policy and the guidelines for mental health services in Head Start, the Mental Health Professional periodically observed children and consulted with teachers and other staff. The Psychological Consultant made initial center visits to observe the children and staff during September and October. No regularly scheduled return visits were made except upon a needs basis only.

During the initial visit, the Psychological Consultant outlined for the staff, techniques for observing children displaying atypical behavior. The consultant then advised staff on how to work with the social, emotional, and educationally maladjusted child. The consultant further provided assistance to the staff on behavior problems and on handicapping conditions.

The center staff then determined when a return visit by the Psychological Consultant was needed. The Center Coordinator contacted the Health Specialist who informed the Psychological Consultant of center staff requests and set up any appointments.

When a return visit for observation of a specific child occurred, the center staff was responsible for keeping an observation record and a written summary of the concerns of this child. Using the observation records and summaries the staff had recorded, the consultant had knowledge as to what methods had been tried, how effective the efforts had been, and the results which occurred.

After an observation visit, the Psychological Consultant then discussed with the center his findings and recommendation. At times, the consultant also followed-up with a written summary. One copy of the report was kept in the child's center file and another copy was kept in the central office.

Parent Training and Crisis Counseling

The formal training for parents was conducted in a 2-hour meeting which focused on guidelines for determining normality in children.

There were approximately 8 hours of crisis counseling for six parents, although the nature of their problems were unspecific.

Service to Children

The Mental Health Consultant advised and assisted in the screening, evaluation, and provision of special help to children with atypical behavior or development. According to his estimates, approximately 130 hours were devoted to screening and evaluation activities. A trained Head Start team screened each child developmentally in the areas of fine motor, gross motor, concepts and communication skills

by use of the DIAL (Developmental Indicators for the Assessment of Learning). The teaching staff completed a classroom assessment twice during the program year on each child (L.A.P. - Learning Accomplishment Profile). The children who were not at the appropriate developmental levels were referred for evaluations. Teaching staff also requested that other children be evaluated who were not identified by the above assessments.

Referred children were evaluated by a two-member diagnostic team. The team consisted of the Mental Health Consultant who evaluated the child's education and psychological needs, and a communication specialist who evaluated the child's speech and language abilities. From these evaluations, recommendations were made for obtaining services for the children and their families. The team approach was used to determine the extent of any problems indicated by the assessments and to see if an emotional, intellectual, behavioral, or physical problem existed.

The diagnostic professionals, administrative staff, center staff, and parents cooperatively wrote individual program plans for the children diagnosed as handicapped. The individual plan was designed to assure that appropriate services, evaluations, and teaching techniques were carried out.

V. Support System/Resources

Due to the limited funds available for mental health services, the Head Start center in Kirksville, Missouri has actively sought out the assistance of agencies and personnel that could augment the services provided by the Psychological Consultant. One of the most viable agencies available, according to the Mental Health Coordinator, was the Department of Special Education at the Northeastern Missouri State University, largely due to the institutional affiliation and role of the Psychological Consultant. This association had provided graduate students, diagnostic services, and some treatment services for referrals. Other agencies identified by the Head Start Director and the Mental Health Coordinator as viable resources were the Division of Family Services, related to preventive work in child abuse, the Kirksville Counseling Center, and the Regional Center for Developmental Disabled, for referral of Head Start families and children as needed.

According to the staff, another potential resource which had not been realized in the pool of mental health professionals at the Kirksville Osteopathic Hospital, which has failed to employ its skills at Head Start.

VI. Evaluation of Mental Health Services

Overall, the Head Start staff felt that the mental health services

that the program provided were effective, but believed that limited funding curtailed the development of other needed services, particularly primary prevention. Similarly, the Mental Health Coordinator rated the program as effective in fostering self-esteem in children and support to the families. The area in which the program was considered least effective, according to the Mental Health Coordinator, was in assisting parents in recognizing the need for professional counseling and seeking out relevant and viable mental health resources in the local community.

Laredo, Texas (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Head Start program located in Laredo, Texas is operated by the Texas Migrant Council which is a private non-profit tax-exempt organization. Laredo, which is in Webb County of South Texas, has a population of 73,859, including 14,000 migrants. The migrant population, predominantly Spanish-speaking, resides in Laredo during the winter months and migrates to the Western and Midwestern states of Washington, Oregon, Illinois, Indiana, Ohio, Wisconsin, Michigan, and Kansas, during the summer. According to data and statistics in the initial grant proposal, the population is 85.6% Chicano, 12.6% White, and 1.7% Black. Census data indicates that the median family income is $4,978, with 39.5% of the families below the poverty level. The median educational level of the population in Laredo is 4.6 years of schooling.

The Texas Migrant Council in Laredo has the capacity for serving 145 children, ranging in ages from 2-1/2 to 5 years of age. There are three classrooms at the center. The program operates 9 months in the homebase area of Texas and for 3 months in the Northern user states, consistent with the migratory nature of the population residents. Thus, all of the programs associated with the Texas Migrant Council migrate northward with the families. The regular Head Start program is five (5) days per week for 7-8 hours per day, although the service day is longer during the three (3) summer months that families are in the Northern states.

II. History and Start-Up of the CFMH Project

The extreme poverty, high transcience of the Spanish-speaking population and the detrimental environment associated with the farm work, involving both physical and psychological hazards, led the Texas Migrant Council-sponsored Head Start program to apply for the CFMH grant. The key personnel involved in the planning and development of the grant proposal for the Child and Family Mental Health Project included the Head Start Director, other Head Start staff, a planner from the Texas Migrant Council, and a collaborating mental health agency.

The CFMH Project officially started in September 1977. According to the Head Start Director, there were start-up difficulties associated with the recruitment and hiring of consultants and staff. Although this problem was eventually resolved, there were also problems with staff turnover in the CFMH Project. There had been four different Mental Health Workers and two Mental Health Supervisors during the two years in which the CFMH Project began. At the time of the site visit, the most recent Mental Health Supervisor was no longer with the program and had relocated to another part of Texas.

Thus, he was unavailable for an interview. However, a recently hired Mental Health Worker, trained at a Bachelors level in child development, had been on staff for five months.

III. Project Structure, Administration and Coordination

The staffing of the $19,800 Child and Family Mental Health Project was comprised of a Mental Health Worker, a paraprofessional, and a Mental Health Supervisor. The Mental Health Worker, employed 100% time, provided all of the services to the Head Start staff and families. The Mental Health Supervisor provided support consultation, training, and supervision and was contracted for 2 days a month.

The Head Start Director was administratively responsible for the CFMH Project and was the person from whom the Mental Health Worker received specific assignments and assistance with any problems, administrative or otherwise. The Head Start Director also monitored the project and evaluated the performance of the CFMH Provider and the Mental Health Supervisor. The Mental Health Worker was designated as the Project Coordinator and, therefore, was responsible for all program planning for the project.

IV. Major Goals, Objectives and Activities of the CFMH Project

The Mental Health Worker described the major Child and Family Mental Health Project objectives as the following:

1. To develop activities and conduct classroom observations to improve the teacher-child relationship.

2. To work directly with the children to improve self-awareness via teachers.

3. To provide consultation to parents through regular home-visits (i.e., children, other problems experienced).

4. To make appropriate referrals of families and children to other agencies.

The overall purpose of these activities was to improve children's self-concepts, to alert teachers to family problems that might have impact on the children, and to relieve any other stresses at Head Start or home that impinge on Head Start children.

The major service emphasis of the CFMH Project, according to the Mental Health Worker, was directed to the Head Start staff via classroom observations and follow-up consultation for teaching staff. Another major service emphasis of the project focused on parent interviews and services and were directed toward children. All records

of CFMH activities and services were maintained by the Mental Health Worker and kept confidentially.

Orientation for Staff and Parents

At the beginning of the year, the Mental Health Worker provided a series of orientation sessions for staff and parents to acquaint them with program objectives, the role of the Mental Health Provider, and the specific procedures and approaches that would be utilized by the project during the program year. Specifically, there were two orientation sessions for staff that lasted approximately 3 hours each. There were 10 staff members in attendance, 6 of whom were teachers. Similarly, the orientation for parents was conducted in a one session that lasted for 1 1/2 hours and was attended by 60 parents and family members.

Staff Training, Child Observation and Consultation

The CFMH Project conducted four training sessions for 10 staff members during the program year. Thus, approximately 12-14 hours of staff in-service training were held. The topics were selected based on a needs assessment survey completed by teachers, recommendations by the Center Director based on her perception of teachers' needs, and suggestions by the CFMH Provider. The primary focus of the workshops were techniques for building self-concept in children, developmental problems of children and discipline issues, etc.

Another major thrust of the CFMH service was the classroom observations conducted by the Mental Health Worker. All five classrooms in the program were observed. Generally, classroom observations were conducted twice a week for a total of 160 hours, during the last 5 months. The observations were focused on issues such as the teacher-child relationship, classroom environment, and classroom activities for children.

Following the classroom observations, the Mental Health Worker regularly met with the teachers/staff to discuss the observations. The Mental Health Worker estimated that 200 hours had been spent in consultation to staff. Although the consultation occurred twice a week on a regular basis, sessions were also held upon staff's request. These sessions were, at times, based upon the home visits conducted by the Mental Health Worker. The most typically discussed topics were problem children (i.e., "hyperactive" or withdrawn children), family problems and issues, classroom management, health status of children, etc. However, at other times, the Mental Health Worker provided the staff with curricular input related to how to encourage creativity, spontaneity, and how to foster positive self-esteem.

Parent Training and Crisis Counseling

According to the Mental Health Worker, the CFMH Project conducted two training sessions for parents, with each session lasting 1-1/2 hours, and reaching a total of approximately 65 parents. The education and training involved formal presentations and workshops. The topics for the sessions were selected by the Center Director and the CFMH Supervisor. The most common issues discussed involved problems of child-rearing such as crying, stealing, and techniques for management and discipline. Also, normal stages of child development were frequently described and discussed.

The Mental Health Worker provided crisis counseling to 10 parents during the program year. The crisis counseling generally occurred during the home visit and lasted on an average of 2 sessions per parent. The most common problems for which counseling was provided were marital issues and health problems of children. Approximately four of the parents were referred to outside agencies for concerns generally related to limited economic resources.

Services to Children

Although the CFMH Project did not provide any formal diagnostic or treatment services to children, there was an overall screening of all 4- and 5-year old children for adequacy of self-concept.

V. Support System Resources

The Head Start Director and the Mental Health Worker reported that there were minimal facilities or resources that would assist the Head Start program with its primary prevention efforts. However, they indicated the state agency for mental health and mental retardation had been helpful in providing some staff training.

VI. Evaluation of the CFMH Project

The Head Start Director is the staff member with the primary responsibility for the evaluation of the CFMH Project and the performance of its staff. The principal mechanism utilized for monitoring the project is the monthly report submitted by the Mental Health Worker to the Director. This report outlines the specific goals and objectives for the month and the activities planned to implement them. The Head Start Director rated the service and activities of the CFMH Project as effective, particularly the staff training and parent education. Yet, he indicated that the program needed more mental health consultation provided by a Mental Health Professional to the Mental Health Worker.

The Mental Health Worker was also satisfied with the overall CFMH Project and her role and performance of her work responsibilities. In fact, the Mental Health Worker reported having observed changes

in both staff and parents as a result of the project. She noted, in reference to Head Start staff, that they were more open to feedback and understood more about the needs and development of young children. The parents, according to the Mental Health Worker, displayed more interest in the children in the home and the classroom and sought more assistance from Head Start staff.

Live Oak, Florida (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Live Oak Head Start program is administered by the Suwannee River Economic Council and services rural counties in Central Florida--Columbia, Hamilton, Lafayette, and Suwannee Counties. These counties range in population from 25,250 (Columbia County) to 2,892 (Lafayette County) with a total population across the counties of 49,570. Approximately 30% of the population of these counties have incomes below the poverty level with the median family income being slightly less than $7,182 yearly for a median household size of 3.2 persons. However, the unemployment rate for these four counties is very low--3.2% for Columbia, .5% for Hamilton, 1.8% for Lafayette, and 2.1% for Suwannee Counties. Also, the median education levels range from a high of 11.0 years for Columbia County to a low of 8.5 years for Lafayette County. Throughout these four counties, 27% of the population or 13,387 persons are Black. Interestingly, however, this population is disproportionally distributed among the four counties, with Columbia County being 25% Black; Hamilton County, 40% Black; Lafayette County and Suwannee County, respectively, having 11% and 27% Black populations.

The Live Oak Head Start program has total funds of $262,425 for the 1978-79 fiscal year to service its children five hours a day for nine months of the year. The Child and Family Mental Health Project of the Live Oak Head Start program was funded for $14,300 in 1978-79 and services one single-class center in each of the four counties.[6] A total of 72 children (or about 18 children per center) are thus involved in the CFMH Project. Fifty-seven percent of the children attending these four centers are Black; the remaining 43% are White. The children range in age from 3 to 5 years old. However, the vast majority of the children are 4 years old; sixty-one of the 72 children currently being serviced are 4 years old.

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[6]Since its funding, the Live Oak Head Start program in Central Florida has expanded its operations to include two additional centers. These centers are not, however, serviced by the CFMH Project due to insufficient funding. However, staff members from these centers are invited to attend all staff orientation and training activities. Thus, the above statistics reflect demographic data on the four counties and the four Head Start centers receiving CFMH funds and services and they do not reflect data on the whole Head Start Program.

The Suwannee County Head Start Center in Live Oak is the program's central office. The other centers, 18-24 miles away, are readily accessible via highway from Live Oak. Most children in each center live within a 5-mile radius of their center. However, some children in Lafayette and Hamilton Counties live as far as 20 miles away.

II. History and Start-Up CFMH Project

The proposal for the Live Oak Head Start Child and Family Mental Health component was a joint product of the Head Start Director and the local mental health agency, the North Central Florida Mental Health Center. Their proposal called for consultants from the CMHC to work with the four Head Start centers. Five consultants were assigned to work with the project.

Start-up difficulties primarily centered around poor communications between the Live Oak Head Start program and the Administration for Children, Youth and Families' central office. The current director (who had come to the program since the CFMH Project was funded) noted that there had been difficulty in obtaining confirmation that their proposal had been funded and difficulty in receiving the start-up funds. The problems caused a delay in the start-up of the program of about a month. Thus, the project began operations in October 1977 rather than September 1977.

Since all the consultants came from CMHC, there were no special procedures to recruit the providers for the program. In fact, all providers were selected by the local CMHC and not by the Head Start program. One change in the consultants occurred during the first few months of operation of the program. One consultant was replaced two months into the program's operation due to his/her inability to relate to the parents and teachers. Unable to fill all 6 consultant positions in the first year of operation, only 5 consultants worked with the CFMH Project during the 1978-79 year. Although there have been few changes in CFMH Consultants, there have been numerous changes in Head Start staff and staff at the Community Mental Health Center. Also, some staff complained that the frequent changes in duties and/or assignments of the CFMH consultants over the two years, disrupted the project's operation. Finally, a new Field Specialist was assigned to the program after its first year.

III. Project Structure, Administration and Coordination

The CFMH Project for the Live Oak Head Start program was structured such that the Head Start Director, designated as the Project Coordinator, shared many of the administrative duties with two (2) of the consultants assigned to the program. The director had primary responsibility for monitoring the project, evaluating the performance of the providers and also shared the planning for the project with 2 consultants. The consultants were responsible for making specific

assignments within the project, dividing the responsibility for the coordination of centers in Hamilton, Columbia and Lafayette Counties. One of the consultants/coordinators gave the following as their principal responsibilities: (1) to supervise services providers, including helping in development of materials and in-service delivery; (2) to ensure that proper documentation existed for each contact; (3) to conduct in-service training; (4) to provide back-up for consultants; and (5) to meet monthly with other consultants to coordinate the project.

In general, the five (5) consultants worked approximately 4 to 8 hours per month. Each was assigned to provide services to one or two specific centers within the program. Although the intent may have been otherwise, some of the consultants saw their work as being independent of, and uncoordinated with that of the other providers. Monthly consultant's meetings with the Head Start Director, the Parent Involvement Coordinator, and the Health Coordinator were, therefore, not completely effective in integrating the efforts of the Mental Health Consultants.

The internal coordination between the CFMH Project and the other program components was easily accomplished since most of the Head Start staff "wore several hats." For example, in addition to serving as the CFMH Project Coordinator, the Head Start Director was also the Education Coordinator. To further ensure effective program coordination, the staff met monthly to plan and discuss their respective areas of concern.

IV. Major Goals, Objectives and Activities of CFMH Project

1. To provide parents with an understanding of child growth and development, a sensitivity to developmental problems, knowledge of effective child-rearing practices, child management, and identification of adult attitudes and behaviors that contribute to a healthy climate for growth. (sic)

2. To strengthen and expand the capacity of the staff to handle the crisis of situations as developmental stress points as an integral part of primary prevention; to promote this understanding of normal child growth and development, techniques for observation required to identify children's needs and develop an individualized program, techniques of child management and identification of adult attitudes and behaviors that contribute to a healthy climate.

3. To strengthen staff skills to handle the crisis of developmental stress points, via the use of small group consultation by a mental health professional with Head Start staff.

4. To provide crisis intervention as needed to strengthen parents' skills in dealing with challenges which are inherent in the transitions from one psycho-social developmental stage of life to the next as well as with situational crisis that occur in life. (sic)

According to the interview data, the greatest emphasis during the 1978-1979 program year was, in fact, placed on staff training and services to children. The training and education of parents received less priority. This is partially a result of the evaluation of the program's first year of operation, during which it was noted that parent participation in training sessions was less than desired. Parent attendance at training sessions was particularly low in two of the four counties serviced. Thus, the renewal grant proposed that home classes and individual home instruction be provided to parents where needed. The available information suggest that some home sessions were held. However, in general, parent education and training received less consultation time than in the previous year.

The absence of systematic record-keeping by the numerous providers in the Live Oak CFMH Project, to some degree, complicated the process of collecting data on the program's 1978-79 activities and services. However, since all the CFMH staff and consultants worked, at most, 16 hours per month, it was difficult for any one person to provide an accurate account of the total project activities. Thus, the following descriptions should be seen as the "best estimates available" of the program's activities during the year.

Orientation for Staff and Parents

Orientation sessions were held for both staff and parents during the 1978-1979 program year. Their one-hour staff orientations were conducted at each of the program centers. A total of six parent orientation sessions, totalling approximately 10 hours, were also conducted.

Staff Training, Child Observation and Consultation

Two staff training sessions were conducted for all four counties. These in-service meetings primarily focused on the role of the teacher in fostering children's growth and development. Each session lasted an average of 6 hours. Approximately 15 staff participated in these training sessions.

Child observations and consultations were conducted regularly by consultants at each center. Most of these consultations were problem-oriented and tended to focus on disruptive or withdrawn behavior in Head Start children. However, specific data was not available on the total number of consultations for observations provided during the year.

Parent Training and Crisis Counseling

Approximately 95 total contacts were made with parents for purposes of training or education. Most of these contacts occurred during home visits. Since some parents were contacted more than once, no accurate estimate of the total number of parents contacted is available. Parent training sessions, thus, tended to be individually oriented and tended to focus, according to one Provider, on issues of discipline, stress and coping.

When crisis counseling was necessary, referrals were made to appropriate agencies. It is estimated that approximately 15 total hours were spent in crisis counseling of parents during the 1978-79 program year. No records of the total number of referrals were kept by the project.

Service to Children

Although no estimate was available as to the total number of hours spent in service to children, one provider did indicate that contacts with children included one-to-one therapy with identified children and group educational activities. However, the exact number of children receiving one-to-one therapy sessions was not ascertainable from consultant records.

V. Support System/Resources

The Live Oak CFMH Project suffered from a death of internal and external support for its activities. Although the Head Start Director also served as the CFMH Coordinator, there was some disagreement as to how much support she was actually able to provide to the project. With respect to external resources, CFMH staff reported an absence of support from additional agencies and professionals outside the Head Start program. This was probably at least partially the result of the Live Oak Head Start program being located in a rural area generally lacking in community resources. Finally, there were notably few young black mental health professionals in the Live Oak area to utilize as resources for the project. This fact, noted by one of the interviewers, was considered significant, given the racial composition of the Live Oak Head Start program.

IV. Evaluation

Parent and staff evaluation forms were administered to participants in each training session as a means of assessing the effectiveness of the Live Oak CFMH Project. Respondents expressed a fair amount of dissatisfaction with the project's current operations. For example, the Project Director expressed concern about the project's ineffectiveness with parents, especially in one-to-one contacts. She also felt the consultants did not evidence a complete understanding of Head Start goals and objectives. However, she did feel

the project was more effective in working with staff and teachers through seminars and other in-service training activities. Staff evaluated the parent group activities as being more effective than other aspects of the project.

One of the consultants interviewed was generally satisfied with the project, while the other expressed some dissatisfaction. The latter consultant's dissatisfaction stemmed from the problem-oriented emphasis, as opposed to prevention orientation, of Head Start staff and from the numerous changes in staff and responsibility changes that occurred during the project's operation.

Finally, the teacher interviewed expressed some satisfaction with the services provided by the CFMH consultants. She, however, qualified her statements about the project, noting that only some of the CFMH services and activities were appropriate to the needs and concerns of Head Start teachers. In closing, she expressed a desire to have group meetings between consultants, parents, and staff reinstituted.

Reno, Nevada (Experimental)

I. Demographic Characteristics of the Community and the Head Start Program

The Reno, Nevada Head Start program serves families from the communities of northeast Reno, Sparks, Black Springs, Stead, Lemmon Valley, and Sun Valley, located in Washoe County. At one time, a predominantly rural county, the area has rapidly become more urbanized. The recent shift in the county's major industry from gambling to commerce has contributed to an increase in its population from 80,000 to 149,685 over a 10 year period.

The city of Reno, the largest population center in the county, and its periphery have some unique characteristics as a result of being a "24-hour city" and the seat of the gambling industry in northwest Nevada. For example, the ready availability of employment attracts large numbers of people to the Reno/Sparks area. The nature of the job market, however, contributes to transcience and community instability. The shortage of adequate and affordable housing in Reno and its adjoining communities further compounds this problem. Sun Valley, for instance, though principally comprised of mobile housing units, has nevertheless experienced a growth rate of 400% since 1970.

In Washoe County, whites account for 91% of the total population. Hispanics make up 5% of the county populace, while Blacks and other ethnic groups form the remaining 4%. Among these various groups, the median income ranges from a high of $16,350 for Hispanics to a meager $8,200 for blacks. One-tenth of the residents of Washoe, primarily those from minority groups, are classified as being below poverty level.

Plagued by many of the problems experienced by larger, more urbanized regions, Washoe County suffers from various social and economic problems--high incidence or crime, low educational attainment among residents, poverty and the lack of adequate housing and transportation systems, etc. Additionally, because Nevada is one of the least densely populated areas in the United States, many of its cities lack the well-developed service networks found in more populated states. Finally, since Nevada collects no state income tax, municipal governments here do not have a traditional tax base for effectively resolving many of their socio-economic problems or financing the provision of human services.

The Head Start program in Reno is administered by the Education Division of the Washoe County Community Service Agency (CSA). CSA provides much needed social services to families in its catchment area. As does its grantee, the Head Start also places a great deal of emphasis on ensuring that comprehensive services are available

to families, thus embodying an "ecological approach" for impacting children's growth and development. Both Head Start and CSA act as advocates for children and their families, helping them to develop strategies for coping with personal and economic situations they encounter.

The Head Start Center in Stead, housed in former military facilities, has three part-day classes which serve approximately 120 children between the ages of 2-5 throughout the year. Some of the children receive services through a home-based program. With additional state funds from the Nevada Division of Mental Hygiene and Mental Retardation, CSA operates the Community Training Center at the Stead site, serving a maximum of 10 children (3-5 years old) with learning disabilities. All children attending the center are transported to and from classes by Head Start.

II. History and Start-Up of the CFMH Project

Upon receipt of the Request For a Proposal (RFP) from the Regional Office of ACYF, the Head Start staff and consultants from local mental health and social agencies collaborated on the development of a plan to implement the Mental Health Worker model of the Child and Family Mental Health Project. Funded for $16,000, the project began officially operating in the Fall of 1977.

The program's Social Services Coordinator was selected to serve as the Mental Health Worker (MHW) for the CFMH Project because of her knowledge and experience in working with families and community agencies in the Reno/Sparks area. The Mental Health Consultant, a private practitioner from California, was chosen to provide support and supervision to the Mental Health Worker during the first year of the project's implementation.

Within the initial start-up period, the project encountered several difficulties. A delay in receipt of funding caused the project to begin slightly off schedule. More importantly, the resistance met by the Mental Health Worker from both staff and parents, further hindered operations. Staff, uncertain of the ability of a Social Services Coordinator to handle more difficult and sensitive mental health issues, did not offer her their complete support (this matter was exacerbated by the fact that no new Social Services Coordinator was hired for several months, so that the Mental Health Worker functioned in <u>both</u> capacities). Parents, not surprisingly, were hesitant about accepting the Mental Health Worker in her new role and were "put off" by the mental health emphasis of the entire project. Further, the supervising Mental Health Consultant assigned to the project had only minimal contact with the Mental Health Worker because he commuted a great distance. To address the most serious problem, the Mental Health Worker tried, unsuccessfully, to have her title changed, in hopes that the elimination of the

ominous "mental health" would dissolve staff/parent scepticism. Instead, she found that increased education and training for both groups were necessary to win their acceptance of the project overall, and her role within it. Next, to insure that she received adequate supervision, a new Mental Health Consultant, an assistant professor from the University of Nevada at Reno's Psychology Department, replaced the first consultant by September 1978.

Other less critical concerns addressed by the CFMH Project and the total Head Start program, in general, during the 1977-78 year included: (a) low parent participation, (b) high staff turnover (approximately 50%) which necessitated continual reorientation to project goals and objectives, (c) interpersonal difficulties between the Head Start Director and the new supervising Mental Health Professional, and (d) the lack of appropriate mental health resources in the community. Through the concerted efforts of the Head Start/CFMH staff and the assigned Field Specialist, most of these problems were sufficiently resolved.

Successes resultant from the CFMH Project, as assessed at year's end included changes in staff attitudes regarding the project, parent orientation, and workshops for parents and staff. The Mental Health Worker also instituted a multi-cultural program into the project activities to encourage Spanish-speaking children to share their language with their peers and, in turn, learn English from them. Audio-visual materials in Spanish were developed for use in each classroom.

III. Project Structure, Administration and Coordination

As previously mentioned, the Mental Health Worker and the Mental Health Consultant formed the core of the CFMH staff. The worker, though considered a paraprofessional, nevertheless held a Bachelor's degree in social service from the University of Nevada, and had several years experience working on crisis "hotlines." The Mental Health Professional, though primarily involved with adult counseling and therapy, had previous experience working with the Reno Head Start program.

As the principal full-time person, the Mental Health Worker was responsible for planning, coordination of activities, and service delivery within the project. She, however, did receive as necessary, direction and assistance from the Mental Health Consultant, the Head Start Director, and the Education/CFMH Coordinator. Generally, the Mental Health Worker's duties involved:

1. Program planning for implementation of CFMH activities and services,

2. Assisting the staff (including the 6 Home Visitors) to incorporate mental health principles and activities into their work with children and families in the classrooms and homes,

3. Conducting parent and staff orientation and training activities,

4. Identifying and utilizing available community resources to address the needs of parents, children and staff within the program; and

5. Performing administrative and record-keeping functions related to the CFMH Project (monthly work schedules, reports to the Policy Council and Health Services Advisory Committee, etc.).

The Mental Health Consultant was contracted to provide, minimally, one day monthly of training, consultation, and supervision to the Mental Health Worker and to assist her in conducting classroom observations. Case consultation sessions during which the consultant reviewed and critiqued the worker's activities or discussed the worker's concerns and interests might last from 4 to 12 hours each. Additional in-service support between monthly contacts was provided through telephone consultations.

In certain cases, the Mental Health Consultant was prepared to participate jointly with the worker in conducting CFMH activities. One workshop, for example, in 1978-79 was developed and presented by both providers. The consultant was also involved closely with the project's community liaison and advocacy work by identifying and contacting viable resources in the area.

The Mental Health Consultant, as well as the Mental Health Worker, reported directly to the Education/CFMH Coordinator. The coordinator, a senior full-time staff member, was first responsible for supervising all educational staff and component activities. Her specific duties, however, with regards to the CFMH Project were to: (a) attend all supervisory meetings between the MHW and the consultant, (b) assist the MHW in planning for mini-conferences and in-service training for staff, (c) periodically evaluate the MHW's performance, (d) hold case conferences with the MHW and other component coordinators around particular families, children who require special services, and, (e) participate in the planning of all educational workshops for staff and parents.

The coordinator estimated that she devoted approximately 12 hours per month to these CFMH related functions.

The Head Start Director, though not actively involved in the daily operations of the CFMH Project, handled most of the fiscal and other administrative matters related to its implementation. He addition-

ally participated in monthly staff meetings, planning sessions and received status reports from the CFMH staff.

Services and activities within the CFMH Project were internally coordinated with those of the entire Head Start program through weekly administrative staff meetings--4-hour sessions used for overall planning, assessment and review of past activities. Other informal meetings between the MWH and the Education/CFMH Coordinator ensured that the project was effectively integrated with other ongoing program activities and services.

IV. Major Goals, Objectives and Activities

To successfully implement the Mental Health Worker Model of the CFMH Project during its second year, the Reno Head Start carefully specified goals, objectives, and activities designed to:

1. Train and provide adequate supervision for the MHW in support of her role as primary mental health provider,

2. Provide orientation regarding the purpose of the project and present relevant information about primary prevention, mental health, and child development to staff and parents,

3. Conduct classroom observations and provide staff with support and small-group consultation,

4. Conduct education and training activities for parents and staff, and

5. Provide counseling and crisis intervention to parents and staff.

Training and Supervision of the Mental Health Worker

During monthly on-site training sessions, the Mental Health Worker and consultant would spend at least one half-day observing classes, consulting around the cases of specific children, reviewing the MHW's progress, or addressing concerns brought to the worker by parents, teachers, and home visitors. Planning and other administrative activities were often handled during these meetings. In 1978-79, only one activity, a workshop on discipline for staff and parents presented by the consultant, was conducted as a training/demonstration model for the MHW. Few other formal activities for parents or teachers were jointly conducted by the providers during the project's second year.

Despite the consultant's participation in the project far beyond the time commitment as per her contract, neither she nor the MHW believed that adequate supervision and training had been provided during the second year. The consultant felt that the design of the MHW model itself did not allow for sufficient training for a paraprofessional

and that the money allocated for consultant services was not substantial enough to purchase the amount of time necessary to provide effective support, training and supervision. The MHW, presenting a different perspective, reported that with each change of consultants, the emphasis of the project changed (i.e., from child-oriented in the first year to adult-oriented the next). Thus, she had received little consistent training or supervision over the entire two-year existence of the project.

Orientation for Staff and Parents

The MHW devoted approximately 60 hours, including preparation time, to the orientation of parents and staff at the Stead center. Having learned during the previous year the importance of this component of the project to its overall success, she attempted to lay a firm foundation for the Year Two through the initial introductory sessions and activities. Unfortunately, since only half of the Head Start staff returned in the Fall of 1978, the MHW was again faced with introducing the unique CFMH Project to a completely new group of teachers. By holding two orientation sessions, the MHW planned to address the problem of orienting people with varying amounts of exposure to the project.

First, in an initial orientation session for all staff, the MHW presented a general description of the project--its intent, goals, activities, etc. Next, newly-hired teachers and staff attended a second meeting where they were provided with more specific information about the MHW's function and their own roles and responsibilities within the project. All staff received a CFMH operations manual, a collection of materials used in the previous year, and mental health activities for incorporation into classroom curriculum. Finally, the MHW elicited input from the staff regarding their interests and needs for the upcoming months.

The orientation for parents was less formal, consisting of a social/recreational activity during which the MHW generally described the project's activities and services. This two-hour meeting was held during the first month of the program year.

Education and Training for Staff and Parents

Prior to the CFMH Project, mental health education and in-service training were provided by consultants in response to identified program needs. Funds for these activities generally came from the program's mental health or training and technical assistance budgets. With the implementation of the project, however, the Head Start staff received training in child development, behavior management techniques, and mental health on an on-going basis.

During the CFMH Project's second year, the MHW spent at least 15 hours each month conducting in-service training. Two-to-three hour workshops on handling personal stress, normal child development and behavior, nutrition, and children's literature were held monthly for center staff. Other topics of interest to staff, ascertained through teacher questionnaires or from informal input, were presented throughout the year. Materials developed by the MHW or provided by the consultant and Field Specialist were often available to participants.

Parent participation and interest in CFMH education and training activities, as noted earlier, was extremely low throughout the project's first year, while parents eagerly attended other more socially-oriented events held at the center. Capitalizing on these facts, the MHW designed the parent training component to contain more informal, social events rather than workshops or didactic training sessions. A handicraft group which met weekly was developed to get parents out of their homes and involved in center-based activities. Typically, during these activities, the MHW engaged parents in discussions about child-rearing, personal issues, politics, or family life. In this relaxed atmosphere, the MHW reported, most parents became more open and receptive to talking about mental/child development issues. Other family orientation activities were also held as part of the parent education and training component.

Counseling and Crisis Intervention

In accord with the preventive emphasis of the CFMH Project, an important objective was directed at addressing families' and staff's need for assistance during crises or stressful situations. Under the supervision of the Mental Health Consultant, the MHW was available to provide counseling, crisis intervention, and make referrals as needed. In conjunction with a MSW and psychologist from C.O.P.E. (Channeling of Parental Energies), a counseling program originally developed for abusive parents, the MHW began a support group to include other parents from Head Start and the community at large.

Approximately fifteen parents during the year received counseling around marital, child behavior and management, personal and psychological problems through the CFMH Project. The majority of the counseling, however, was short-term, consisting of three or four one-hour sessions. When parents required more intense counseling or other services, they were referred to the appropriate outside agencies.

Classroom Observation and Consultation

Regularly during the year the MHW conducted general observation of all three classrooms at the Stead center. These observations focused on child/staff interactions, the children's social functioning

within various situations, and the overall classroom environment. At other times, classes were videotaped for later use in consultation sessions with teachers. Finally, based upon prior observation or teacher request, the mental health worker conducted occasional child-specific observational sessions with the Education/CFMH Coordinator.

Support or follow-up consultation with teachers and aides required at least 16 hours per month of the MHW's total time. Meeting individually with staff members, the MHW dealt with normal child development issues, teachers' personal concerns, as well as child behavior and management or home-related problems. During an average two-hour session, the teacher or home visitor and the MHW might discuss curriculum and develop plans to incorporate primary preventive concepts within classroom and home activities.

Direct Services to Children

Although no direct services were provided to children at the Head Start center, the MHW would often interact with children during classroom observation to demonstrate particular behavior management or intervention techniques. Similarly, she might work directly with children as part of her assessment and referral of children requiring special assistance. However, formal screening, diagnostic and treatment services were provided for all children in the program by various mental health agencies under the Head Start mental health component.

V. Support System/Resources

The identification and utilization of mental health and primary preventive resources was an important function of the CFMH Project, particularly for the Reno program. Many of the Mental Health Providers in the area--for example, the Sierra Developmental Center, the Children's Behavior Service, the Nelson Learning Clinic, and the Special Children's Clinic--served only school-aged children or those with severe disabilities. Private practitioners in the region, pediatricians and psychologists, were generally too expensive or not culturally sensitive to the needs of Head Start children. Thus by devoting portions of the MHW's and consultant's time to community liaison work and family advocacy, the Reno Head Start was working to extend its network of viable mental health resources.

Although not completely successful in identifying preventive Mental Health Providers [illegible]ervices, the CFMH staff nevertheless played an important role in educating agencies about the need for such services for preschool children. To some degree, the support and technical assistance provided to the program by the University of Nevo at Reno campus's School of Home Economics (the Child Development/Family Life Section), College of Education, and the College of Social Sciences (Psychology Department), had a primarily preventive

impact on staff and parents. Traditional mental health services--evaluation, diagnosis, and treatment, were available through most of the agencies mentioned previously. Unfortunately, the MHW reported that these services were provided to the program neither adequately nor promptly.

VI. Evaluation of the CFMH Project

The Head Start/CFMH staff generally acknowledged that the project had experienced several difficulties since its inception (high staff turnover, insufficient supervision of MHW, low parent/staff interest, and lack of adequate financial resources). Despite these problems, all still conceded that the CFMH Project was a breakthrough as an attempt to provide comprehensive and preventive mental health services to Head Start families and staff.

In assessing the successes resultant from the project's 1978-79 year, the staff noted that teachers, aides, and home visitors profited from having the additional psychological and professional support provided by the MHW and the consultant. By learning to handle personal, as well as children's and parent's stresses, the staff was able to work more effectively within their classrooms and in their contacts with parents. Similarly, the parents who participated in CFMH activities benefited from their exposure to mental health and child development concepts. The MHW related that many parents who had previously been isolated, withdrawn, or uninvolved in Head Start, gradually became more responsive and interested in their child's and the center's activities.

Since the interviews were conducted, the Mental Health Consultant for 1978-79 resigned, accepting another teaching position out-of-state. Another professor from the University of Nevada, who expressed interest in primary prevention and work with preschool children, was hired to work with the project during its third year. The staff, pleased with the selection of the new consultant, is optimistic that the orientation and experience he brings will contribute to even greater successes during the upcoming year.

Tacoma, Washington (Experimental)

I. Demographic Characteristic of the Community and Head Start Program

The Tacoma Head Start program is located on Pudget Sound, approximately 45 minutes from the city of Seattle, in the state of Washington. Tacoma has a population of 154,581 with 19,061 or 12.6% of the population below the poverty line. The ethnic distribution, according to the 1970 census, is 140,301 Whites, 10,436 Blacks and other ethnic groups total 3,844 residents. The principal industries are lumber and aerospace, although there have been recent cutbacks in the aerospace industry. The median educational level of the population is 12.2 years. The unemployment rate is 8.4% and the median family income is $9,859. According to program reports, the incidence of child abuse in Washington is one of the highest in the country.

The grantee organization is the Metropolitan Development Council, while this delegate agency for the Head Start program is the Tacoma Public School System. The Head Start program which has a budget of $711,278, has 14 classrooms and serves 275 children. The program operates for three and one-half hours per day, five days a week. To insure racial and ethnic balance in enrollment in the classrooms, public busing is utilized.

II. History and Start-up of CFMH Project

The initiation of the CFMH grant proposal grew out of an already existing collaborative relationship between the Head Start program and the Tacoma Pierce Comprehensive Mental Health Center. As a result of that ongoing relationship, the agencies decided to work together to develop a proposal for the Child and Family Mental Health Project. The participants in the planning and developing of the proposal included the Head Start Director and other Head Start staff, staff from the Comprehensive Mental Health Center, and the Parent Policy Board. The Head Start Director related that there was no formal procedure for recruiting and selecting the mental health providers, since the Head Start program already had a relationship with the collaborating agency. The proposal was funded for $27,000 and officially started in September, 1977. There were no start-up difficulties identified by staff, though subsequently, there have been several staff changes among the Mental Health Providers. That is, in the first year, the mental health center had four different CFMH staff members due to their leaving that agency for other employment.

III. Project Structure, Administration and Coordination

Due to the on-going relationship with the Tacoma-Pierce Comprehensive Mental Health Center, the Tacoma Head Start program selected

the Community Resource Model for the CFMH grant, contracted with the Children's Services Division of the Tacoma-Pierce Comprehensive Mental Health Center to provide professional services, which included 40 hours per week of consultation, training and orientation for Head Start staff and parents. A team of 3 staff from the Comprehensive Mental Health Center were responsible for the delivery of specific services within the contractual agreement, including time for planning and administration.

The overall administrative responsibility for the CFMH Project technically resides with the Head Start Director, although matters of administration and coordination within the mental health teams were the responsibility of the Director of Children's Services at the mental health center. Thus, the Director of Children's Division was responsible for giving specific assignments to their staff and had the responsibility for monitoring and evaluating the day-to-day performance of the CFMH Providers.

Internally, within the Head Start program, no staff person was formally designated as Mental Health Coordinator, although a long time staff member with mental health expertise assumed responsibility for coordinating the "Bug-in-the Ear" program.

IV. Major Goals, Objectives and Activities

Although the Head Start Director was in agreement with the broad goals and objectives of the Child and Family Mental Health Project, the local program had identified the following specific objectives:

1. To initiate a primary prevention plan to foster mental health as a part of the child's normal development.

2. To increase positive interactions between the child and his/her primary caretakers (family and school) as well as with the child's peers.

3. To foster a climate of confidence and an expectation for success for the child in his/her future learning experiences.

4. To develop and strengthen factors in the child's environment at home and at school which encourage curiosity, self-discipline, self-confidence and spontaneity.

The CFMH Project provided a range of mental health services including orientation to staff and parents, consultation and education of staff, etc. The primary emphasis of the program's activities was focused on the Child-Aide Project and the "Bug-in-the-Ear" Program.

Staff and Parent Orientation

The CFMH Project conducted approximately 4 orientation sessions for parents at regularly scheduled parent meetings, reaching about 40 parents. These hour-long sessions presented an overview of the goals and objectives of the CFMH Project and its activities. Also, these presentations described the Child-Aide Project, which paired adults or child-aides and children with developmental or emotional difficulties to provide one-to-one interaction with children.

In contrast to the parent orientation which was conducted in the more formal group situation of a parent meeting, the orientation to Head Start teachers and staff was conducted on an individual basis. The purpose of the staff orientation was primarily to explain the nature and goals of the Child-Aide Project. The primary Mental Health Provider estimated that their staff orientation sessions covered 14-20 hours over the program year.

Staff Training, Child Observation and Consultation

The staff training consisted of an all day workshop for all staff and an ongoing in-service training, workshop and activities. The all day workshop was conducted for 28 staff members, and, covered topics such as prevention of incest, child development, relaxation techniques, etc. The precise number of limit of services for staff training or the number of recipients was unavailable due to staff turnover.

According to the Mental Health Provider, classroom observations occurred infrequently and were conducted only at the classrooms which instituted the Child-Aide Projects. The observation generally lasted between 15 minutes and one-half hour per week at each center, and were directed to children identified by teachers as having some difficulties. At times, case consultation did occur following the observation of children. However, the Mental Health Provider responsible for the supervision of the 6 staff participating in the Child-Aide Project did provide case consultation to Head Start teachers and teacher's aides, which totalled approximately 80 hours during the program year. Consultation related to the "Bug-in-the-Ear" techniques enabled discussions around management techniques, increasing positive interactions, and individualizing instruction. There was no consultation related to curriculum provided to teachers and staff.

Parent Training and Crisis Counseling

The major vehicle for intervening with Head Start parents was the "Bug-in-the-Ear" technique developed by Dr. Kate Kogan at the University of Washington, which has been utilized at the Head Start program for several years. However, the award of CFMH monies allowed the program, initially funded through the Head Start program for

handicapped children, to be expanded to include children without an impairment or falling within the normal range. Essentially, the objective of the "Bug-in-the-Ear" technique was designed to enhance the positive relationship between an adult (parent or teacher) and the child and to assist parents in managing children's developmental and behavioral problems. The activities in the parent training centered around parents and children who are videotaped while playing together. A wireless device (hearing aide) worn by the parent enabled a staff person to communicate with the parent as he/she plays with the child. Also, the videotaped sessions reviewed later by the parents and feedback provided. The "Bug-in-the-Ear" sessions are supplemented by materials from the resource room--for example, an appropriate toy from the toy-lending library. According to the data provided by the Tacoma Head Start program, the "Bug-in-the-Ear" was able to reach 14 parents with the individual sessions and 4 group sessions. Other parent workshops were held, lasting 2 hours each, on topics such as child development, child management and positive interaction.

There was minimal crisis intervention by the CFMH Project. In fact, only 1 parent received crisis counseling. She was identified during the "Bug-in-the-Ear" exercise and was counseled during an hour-long session.

Services to Children

Although the CFMH Project did not provide formal diagnostic or treatment services, some direct intervention with children did occur via the Child-Aide Project. The Child-Aide Project, based on Primary Mental Health Project in the Rochester Public Schools, was designed to detect and prevent problems and behaviors that might seriously affect a child's present and future behavior, particularly in a learning environment. Thus, all of the 280 children in the Head Start program were screened based on teacher ratings (the Children's Behavior Form which assesses their self-adjustment, school adjustment and child's performance in specific academic areas). This screening took approximately 200 hours to administer and score. Thus, 35 "at-risk" children were identified and assigned to a child-aide, 4 graduate students and 2 parents who are selected and trained by the mental health Head Start team. The child-aides are supervised by one of the CFMH Providers who was trained as a family therapist . The child-aides worked with the referred children at Head Start on a one-to-one basis for 30 minutes twice a week.

V. Support System/Resources

The Head Start Director indicated that he was quite satisfied with the community resources that could be used to support the mental health activities within Head Start, particularly the Comprehensive Community Mental Health Center. However, he identified several

problems that were associated with the level of adequate organization and coordination between Head Start and the Tacoma-Pierce Comprehensive Community Mental Health Center, the collaborating mental health agency. In fact, he acknowledged several difficulties that might not have occurred had the CFMH Provider been on staff rather than a consultant. The specific criticisms of the use of staff from the collaborating agency included:

1. Unavailability to handle crises occurring in the center.

2. Limited accessibility to staff and parents.

3. Limited familiarity with Head Start philosophy and programs.

4. Poor coordination of plans and activities with the mental health person on staff.

5. Fragmentation of efforts, poor coordination among the activities of multiple consultants.

6. Too many consultants involved on too limited a basis for good working relations to be developed with centers.

VI. Evaluation of the CFMH Projects

According to the Head Start Director there were no formal procedures for either monitoring or evaluating the performance of the CFMH Project staff. Despite the absence of formal mechanisms for evaluation, the Head Start Director rated the overall services as "effective." In particular, he felt that the "Bug-in-the-Ear" Program had been the most effective, especially as a tool for upgrading parent-child interaction. He rated the staff training as the least effective and felt that the coordination between the Head Start program and the Mental Health Center remained an unresolved problem.

The supervisory staff member from the Comprehensive Community Mental Health Center described herself as "dissatisfied" with the performance of the CFMH staff members. Yet, she additionally reported that the CFMH services were delivered promptly, where appropriate, to staff/parent needs, and effective overall.

Troy, Alabama (Experimental)

I. Demographic Characteristics of the Community and Head Start Program

The Troy, Alabama Head Start program is located in a small rural town in South Central Alabama, near the city of Montgomery. The Head Start program serves a five county area which covers 3,349 square miles and Bullock, Butler, Coffee, Crenshaw, and Pike Counties. The total population for the five counties, according to the 1970 census, is 107,929 with five major population centers, none of which exceeds 2,500. The population of four of the five counties are predominantly White, although local Head Start documents indicate that the Head Start enrollment is predominantly Black. Census data indicates that there is considerable range in the economic level of the five counties. For instance, the percentage of families below the poverty level ranges from 46.7% in Bullock County to 19.9% in Coffee County. The unemployment rate ranges from 5.9% in Bullock to 3.3% in Crenshaw. Also, the median educational level of Bullock, Coffee, Crenshaw and Butler Counties is 7.7, 10.5, 8.4 and 8.0 years of schooling, respectively. The area served by the Head Start program has limited social and educational services for young children and their families and there are limited facilities for public transporation.

The Troy, Alabama Head Start program which is funded for $495,587 per year, conducts a full day (6 hours) program for nine months. In addition, children from AFDC families attend Head Start during the summer months with funds from other programs. The program presently serves 291 children from the ages of 2 to 5. The ethnic distribution is approximately 80% Black, and 12% White. There are six separate centers with 15 classrooms among them. One center operates a single class; three centers have two classes each and; the remaining two centers have three and five classes, respectively.

II. History and Start-Up of CFMH Project

After receiving the RFP for the Child and Family Mental Health Project from ACYF in Washington, D.C. in the Spring of 1977, the center engaged in the planning and development of the grant proposal. The persons involved in the process of developing the proposal included the Head Start Director, Mental Health Consultants, representatives of the Parent Policy Council and other Head Start staff. A need for the CFMH Project was particularly indicated due to the limited availability of mental health services to children. The proposal was funded by ACYF for $26,200 and officially started in October, 1977. According to the grant proposal and the interview with the Head Start director, there were several start-up problems experienced by the CFMH project. A major problem area was the concerns expressed by the local and state mental health authorities about mental health services being delivered without their permission and outside their supervision.

Another concern raised by these mental health groups was their initial position that mental health services could not be delivered by Head Start without a license to provide mental health services. Following a series of meetings by the Mental Health Professional with local and state officials, in which the goals and objectives of the CFMH Project were enunciated, the issues were resolved satisfactorily by January, 1978. In addition to these initial problems with local and state mental health authorities, other problem areas identified in the proposal included:

1. Being able to determine what characteristics a paraprofessional Mental Health Worker should have in order to properly recruit a person for such a job.

2. Defining the role of the paraprofessional Mental Health Worker.

3. Supervising the Mental Health Worker within the time limits set by the model design.

4. Developing and securing parent and teacher training materials.

However, the Head Start Director reported that each of these problems was resolved satisfactorily. The problems in definition of the role of the paraprofessional Mental Health Worker and the need to identify the appropriate qualifications in order to recruit properly were resolved by (a) a revision in job descriptions and expectations and by developing a detailed work schedule, and, by (b) enumerating a list of characteristics that Mental Health Workers should possess. Also, the issues raised about the need to provide adequate supervision for the Mental Health Worker was resolved by allocating increased time for intensive and regular on-the-job supervision and training. Finally, funds carried over from the 1978-79 budget of the CFMH Project were utilized to secure audio-visual aides and other training supplies.

III. Project Structure, Administration and Coordination

The key staff for Troy, Alabama Child and Family Mental Health Project were the Mental Health Supervisor and two Mental Health Workers. There was no systematic recruitment for the Mental Health Supervisor, since the Head Start program already had a highly qualified part-time mental health practitioner who had served on the Parent Policy Council and was instrumental in the planning and writing of the initial proposal. He also had part-time staff responsibilities as coordinator for services to handicapped children since 1975. In contrast to the lack of formal recruitment for the Mental Health Supervisor position, the recruitment for the Mental Health Workers was advertised in the newspaper in the five counties for a two-week period. According to the Head Start Director, the program was simply looking for persons that were "mentally alert

and able to deal with poor people." The formal process of the selection of the Mental Health Worker involved the following three steps:

1. Initial screening conducted by the Head Start Director.

2. A screening committee of the Parent Policy Council recommended the first, second and third choice of applicants to the full board.

3. The full Parent Policy Council made the final decision.

There has been a change in personnel, as the two Mental Health Workers for the 1977-78 program year resigned, according to the Head Start Director, due to lack of clarity in their job responsibilities. However, the two positions were filled at the beginning of the 1978-79 year.

The major responsibility for program coordination and planning for the project resides with the Mental Health Supervisor, who is administratively responsible to the Head Start Director. The Mental Health Supervisor, who also serves as the Mental Health Coordinator for the Head Start program, is contracted to provide services related to the CFMH Project for forty-two (42) hours per month. As coordinator for the CFMH Project, he is responsible for specific assignments to the Mental Health Worker and is the person to whom the Mental Health Worker goes with administrative matters and other problems. Thus, he is responsible for the overall monitoring of the project, and, along with the Field Specialist, evaluates the performance of the CFMH Provider. The specific job functions of the Mental Health Supervisor as presented to the Parent Policy Council were to:

1. Supervise and provide support to the Mental Health Workers the first and third Monday of each month for ten months. Eight hours per day, or a total of 160 hours, will be devoted to individual supervision, joint classroom observations, etc.

2. Participate in the recruitment and selection of the Mental Health Workers as outlined in the Management Plan.

3. Participate in the on-going planning for implementation of CFMH goals and objectives at whatever level assistance is required.

4. Assist the Mental Health Workers in conducting a limited number of training sessions if necessary.

5. Assume responsibility for appropriate definition of parent and staff training content and develop materials as necessary, including a series of classroom and individual child observation checklists.

6. Assume responsibility for initial establishment of crisis intervention system.

7. Serve as referral source for children and families needing more than crisis intervention counseling.

8. Cooperate in the preparation of all necessary reports.

9. Serve as liaison with other community resources upon request and/or as the need for such is perceived.

10. Cooperate with children and families upon the children's entrance into public school to insure proper placement, needed services, etc.

11. Serve as a source of information to parents and children needing further services after leaving the Head Start program. Make proper referrals to local and state agencies which can serve their needs.

12. Allocate a certain amount of class time in Child Development Associate program for on-going staff orientation and training in CFMH goals, objectives and activities.

The coordination of the CFMH Project with the various service components of Head Start is implemented through the weekly staff meetings with the Mental Health Workers and the Coordinators of the other service components. In addition, the Mental Health Supervisor conducts individual consultation with the Program Coordinators as necessary. The activities of Child and Family Mental Health Project are primarily provided by the two Mental Health Workers with some assistance in staff and parent training by the Mental Health Supervisor. The Mental Health Workers are employed 100% by the CFMH Project. Although they are not formally trained in psychology, both have taken college coursework.

IV. Major Goals, Objectives and Activities of the CFMH Project

Consistent with the overall objectives of the CFMH Project, data from interviews with the Mental Health Workers as primary providers indicate that the three major objectives of their CFMH Project are to:

1. Foster self-esteem in children.

2. Develop effective parenting skills.

3. Develop effective teaching methods in the classroom.

The providers described a range of activities or services directed to the staff and families of Head Start program. These services included staff and parent orientation, model teaching, consultation and training with staff, parent training, home visits and interactions with children. The Mental Health Workers reported that the CFMH Project placed equal emphasis on all centers in regard to their activities. Each Mental Health Worker was assigned to three of the six centers in which they had primary responsibility. Thus, CFMH Project activities were conducted individually for each center rather than jointly.

Estimates by the Mental Health Providers provide an index of the service emphasis, distribution of services, and number of recipients. According to the Mental Health Worker, the major allocation of time was directed to staff training, classroom observations, and follow-up consultation. Secondary to the focus on staff training and consultation were monthly meetings directed to parents. Also, only limited resources were directed toward crisis counseling for parents. Consistent with a primary preventive focus, the Mental Health Provider did not provide diagnostic screening or treatment for children. In addition to the time spent in providing services to the Head Start staff and families, the respondents reported that substantial time was spent maintaining records, performing administrative tasks, traveling between centers, supervising and planning program activities.

Orientation for Staff and Parents

At the outset of the program year, a series of orientation programs and activities were conducted to familiarize parents and staff with the objectives and activities, and to introduce staff and initiate plans for 1978-79 program year. Staff orientation sessions were conducted for approximately one hour per center at each of the six centers, reaching all of the 30 Head Start teachers and teacher's aides. Similarly, one hour orientation meetings were held for parents at each of the six centers with a total attendance of approximately 38 parents.

Staff Training, Child Observations and Consultation

Based on input from teachers and teacher's aides, along with suggestions by the Mental Health Workers as to appropriate topical areas, weekly training sessions were conducted at the centers for approximately one-half hour to an hour for all of the teachers. Coordinators, administrators and other specialists did not attend. Topics were based on recommendations by teachers, responses to questionnaires and suggestions by the Mental Health Workers developed in

their supervisory sessions. Training models and materials such as "My Friend and Me" kits, and other written materials on early childhood were disseminated. Common topics for the training included classroom discipline, needs of young children, family relations and self-image. Although the total number of hours could not be accurately estimated by the Mental Health Workers, the staff training was conducted approximately once per week per center, with the amount of time per session being variable.

Classroom observations were conducted by the Mental Health Worker in all Head Start classrooms. These observations which generally lasted for one-half hour to one hour, totalled approximately 77 hours during the program year. Although the specific focus of the classroom observations are not clear, the report by one of the Mental Health Workers indicated that the observations were focused on "abnormal behavior." Although regular consultation is not conducted with staff, consultation sessions were held if some unusual behavior was noted during the observations. In addition, however, the Mental Health Workers did provide weekly consultation with individual staff (though unrelated to classroom observations). This ongoing individual consultation was initiated by teachers or the Mental Health Worker focused on behavioral problems or classroom management issues. At other times, it involved providing practical guidance on suggested curriculum topics or recommending materials such as films that might be used in the classroom.

Parent Training and Crisis Counseling

Ongoing parent education sessions were conducted by the Mental Health Workers at each of the 15 centers. Topics for discussion were selected jointly by parents and the Mental Health Workers. The most common topics or issues were centered on basic needs of children, child abuse and neglect, and single parenting. The training sessions were generally for one hour and there were 26 sessions conducted over the program year.

Although crisis counseling was available, there was a limited number of recipients that requested help. During the program year, there were approximately 5 parents receiving crisis counseling, which ranged from one-half hour to one hour. The total number of hours of crisis counseling was approximately eight. The main types of problems for which counseling was provided were issues related to a divorce and child management concerns. The crisis counseling for problems related to child management concerns was conducted at home. According to one of the Mental Health Workers, a major reason for the limited crisis counseling services was that there was an agency which provided crisis services within the community. Two of the parents receiving crisis counseling at Head Start were referred to an outside agency for assistance.

Services to Children

According to the interviews with the Mental Health Worker and the Mental Health Supervisor, there were no formal diagnostic or treatment services provided to children. However, the Mental Health Workers did interact with the children through their model teaching efforts, providing individual attention to children that needed it and, participating with all children in activities such as field trips, parties, etc.

V. Support System/Resources

The CFMH Project was assisted in the implementation of its program by both support within Head Start and outside. The primary internal support was provided by the Mental Health Supervisor, who, in addition to other responsibilities, provided supervision, training, and consultation to the Mental Health Workers. According to the Mental Health Supervisor, he estimated that 12 hours per month were devoted to direct supervision, one hour per month by phone and an additional 5 hours of in-service training. The nature of the supervision involved the Mental Health Supervisor reviewing written records, and tape-recorded sessions and holding regular meetings to discuss problems and issues. The most common issues raised in the supervisory sessions were issues related to motivating teachers and parents to participate, appropriate content for training programs, methods for facilitating coordination between the mental health and education components, interpersonal relationships and group dynamics within the Head Start program. Also, the Mental Health Supervisor provided in-service training to assist Mental Health Workers with the theoretical framework for primary prevention, effective listening skills, identification of defense mechanisms, materials for their parent and staff training, community resources, etc.

According to the Mental Health Coordinator, there was a number of traditional agencies that were used for supportive services to Head Start families. This includes mental health agencies, crippled children's services, Farmers Home Administration, Welfare, etc. In fact, the CFMH staff felt that the project had increased its network of services. Non-traditional resources that the program utilized for assisting Head Start families were the clergy and family members. However, there were a limited number of available primary prevention services.

VI. Evaluation of CFMH Project

Although acknowledging the absence of any formal procedures for monitoring the CFMH Project, evaluating the specific performances of its staff, and determining the adequacy of the supervision, the Head Start Director rated the overall program as "effective." Specifically, he perceived the training with teachers and staff as most effective. In contrast, he rated the program at the central office for

administrative level as less effective than programs at the center level, due to fewer services. Further, he felt that the CFMH Project had been particularly useful in requiring Head Start to work more effectively with other agencies and with building a more positive outlook toward life for parents.

Similarly, the Mental Health Supervisor rated the services provided by the Mental Health Workers to parents, teachers and other staff as "very effective." He felt that there were a number of successful or positive outgrowths of the CFMH Project such as improved staff morale, better integration of service components, increased understanding of mental health and that children were happier.

Finally, the Mental Health Workers were pleased with the overall CFMH Project, their own roles and the performance of the specific tasks for which they were responsible. They perceived that they had a positive impact on teachers' methods and approaches. In assessing parent changes as a result of their intervention, the Mental Health Workers felt that parent participation had increased, there was improved self-image, and improved care provided for their children.

Control instruments for teachers focus on mental health services which parallel those provided by CFMH Projects. Teachers, accordingly, are asked to describe their level of exposure and their reactions to orientation, in-service training, and consultation activities related to primary prevention.

Parent Interview Schedules. Also critical links in the chain of mediated CFMH effects, parents serve as another primary source of evaluative information. Like the Teacher Interview Schedule, the instrument for parents focuses on participation in CFMH activities, the value of each type of participation, the project's relevance to their perceptions of an appropriate role for parents, and the project's effects on them and their children.

Parent interviews at control sites focus on participation in, and evaluation of, activities which parallel those provided by CFMH programs: crisis counseling, orientation to mental health services, and education and training designed to foster a better understanding of child growth and development and the role of mental health, and a variety or other primary prevention topics.

Field Staff

Pilot data was collected by staff of The Urban Institute. Each staff member was assigned responsibility for 1 to 5 sites and discharged the following functions:

1. Act as liaison between the program and the evaluation contractor.

2. Schedule and make all preliminary arrangements related to site visits.

3. Take charge of collection of all pilot data pertaining to the assigned site, including the administration of interview schedules, the acquisition of all necessary documents and materials, and the compilation and transfer of all required information from program records.

4. Prepare administrative reports related to the site visit.

5. Assume responsibility for any follow-up necessary to complete each program file.

Data Collection Tasks and Schedules

The pilot data collection strategy incorporated desk reviews of program documents and materials as well as site visits. As outlined in Table 2.5, it began with the acquisition of the principal source documents from ACYF and the T&TA Contractor which occurred in October of 1978, proceeds through the site visits scheduled for April and May of 1979, and ended with the collection of year-end data and any other materials needed to compile a complete program description.

Field Procedures

Because the late funding of the evaluation threatened to disrupt the data collection schedule laid out in the scope of work, approval was sought and obtained to initiate certain preliminary steps related to field work while other details of the evaluation plan were being worked out with ACYF. Therefore, the following sections describe some steps which have been completed or which are in progress currently, as well as other steps which will be initiated upon formal acceptance of the full plan by the Evaluation Project Officer.

Site Development Procedures. The first step in site development, acquainting CFMH programs with the evaluation design and with The Urban Institute staff, was initiated at the initial T&TA conference held in Colorado Springs, Colorado during November of 1977. The Evaluation Project Director and one of the Senior Research Scientists attended that meeting. Blocks of time were reserved at that conference for meeting individually and in small groups with CFMH Providers, Head Start staff, as well as national or regional ACYF representatives who wished to obtain more information either about the requirements of the evaluation or about the firm to which the contract had been awarded.

At a subsequent training conference held in Brownsville, Texas during January of 1979, both the Project Director and the Project Research Associate made presentations on the evaluation methodology and met informally with conference participants. Therefore, by the time that contacts were initiated preparatory to data collection, at least the Head Start Director and the principal CFMH Provider in most programs were familiar with the general evaluation strategy and with several of the key staff employed by the Contractor.

Formal contacts were initiated by mail immediately following the Brownsville Conference. Letters of introduction were then mailed to each regional office of ACYF and to the Director of each participating Head Start program. Letters to regional ACYF staff outlined the major components and phases of the evaluation, identified participating experimental and control programs within the region, and requested cooperation and support for the evaluation. Both the Regional Program Director and the regional CFMH contact identified by the T&TA Contractor received the introductory letter.

Table 3.2

Phase I Process Data Collection Schedule

OCT 1 - JAN 30	Collect program resource documents from ACYF (including CFMH proposals, printouts of most recent PIR statistics, and from T&TA Contractor (including Year I Report, Field Specialist Site Visit Report, CFMH Operations Manual, etc.).
NOV 1 - DEC 15	SAVI visits: Collect background information from one participating and one non-participating program to familiarize planning staff with Head Start administrative structure and operations, baseline levels of mental health services, record-keeping procedures for CFMH Projects, etc.
FEB 1 - MAR 30	Collect planning data on operations (e.g., vacation and special event schedules, hours of service, availability of central location for interviews, names of parent and teacher respondents, etc.)
APR 1 - MAY 15	Site visits: Collect interview data, record summaries and old requested documents, including current resource directories, PIRs summarizing the current year of operations, contracts with consultants and agencies providing mental health services, resumes of key personnel, program materials reflective of activities for parents and staff, etc.
APR 15 - MAY 23	Follow-up: Obtain any requested items which were not supplied during site visits.
APR 15 - APR 30	Collect/compile census data on pilot programs.
MAY 15 - JUN 15	Year-end wrap-up: Collect any documents and records needed to provide a complete description of project events which took place after the site visit. (To occur within two weeks of the program's last day of operation).

The Head Start Director and designated project contact (usually the CFMH Provider) also received letters outlining the evaluation strategy and timetable. Programs that were considered for a field visit during the pilot year also received a request for the names and job titles of key project staff, a list of persons other than the CFMH Providers who should be interviewed to obtain a complete picture of project operations, optimal times for interviewing, availability of space, and other aspects of the program's operations. The letters of introduction to each program were to be followed up in March by a request for more detailed information on operations (schedule of spring vacation, other program or administrative events, etc.)

Subsequent arrangements were worked out through telephone contacts between the staff members assigned to make the site visit and either the Head Start Director or the person designated by the Director to handle the arrangements. Letters of confirmation were mailed to pilot sites indicating the agreed upon dates for the visit, identifying the specific people to be interviewed, and establishing a tentative itinerary for the visit. The letter also requested that the materials listed in Table 2.6 be available for pick-up and for review during the site visit.

Programs which were not selected for the pilot study were informed that they would be visited in the Fall of 1980. They were asked to forward to the evaluation contractor only the information listed in the bottom portion of Table 2.6. Control programs received the parallel communications appropriate to their inclusion in/or exclusion from the pilot study. Samples of the letters that were sent to each group and all other materials that were used in site development are included in the pilot visit field plan which appears in a separate document.[7]

The final step in site development was to prepare statistical profiles (shown in Table 2.6) and program abstracts which summarize information compiled from the following sources: CFMH proposals, PIR computer listing obtained from ACYF and Field Specialist reports contained in the T&TA first-year project report. Profiles, abstracts, and all supporting data related to each program were placed in separate files created to hold the materials pertinent to each site. Field staff reviewed all information in the appropriate project file prior to conducting site visits.

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[7] Child and Family Mental Health Project Evaluation. Field plan and site visitor's manual.

Table 3.3

Data Request List for Pilot Site

Records and Materials to be Reviewed on Site

1. Staff in-service training activities.
2. Parent Education meetings/activities.
3. Staff consultation.
4. Classroom observations.
5. Counseling and mental health services provided to parents, families.
6. Mental health services provided to children.
7. Mental Health Consultant team meetings (Mental Health Consultant Model only).
8. Mental Health Worker meetings with Mental Health Supervisor (Community Resource Model only).
9. Listing and/or bibliography of materials used for staff/parent orientation and training (with copies provided if possible).

Materials to be Collected for Evaluation Files

1. CFMH original and continuation proposals.
2. PIR(S) from 1976 to the present.
3. Grantee Plan of Action and update from 1976 to present.
4. Resumes of Mental Health Worker, Mental Health Supervisor, Mental Health Coordinator, or other mental health service providers.
5. Listing of types of records kept relating to CFMH contract (or mental health activities in control programs) with brief description of the content and examples of these.
6. Copies of needs assessment or other data used to demonstrate the need for CFMH program.
7. Staff roster (by program and center).
8. Roster of children (by center).
9. Resource Directory.
10. Other materials compiled or developed by program.
11. Most recent SAVI report.
12. Job descriptions of Mental Health Worker, Mental Health Supervisor, Mental Health Consultants, Mental Health Coordinators or other mental health service providers.
13. Any service agreements for agencies providing paid or donated service services.
14. Organizational Chart.
15. Mental Health portion of budget.

Table 3.4

CFMH Experimental Sites - Community Mental Health Resource Model

Site	Amount of Grant	Operation Time	#- Centers	Program Size		Age Group	MH Provider(s)	Ethnic Composition
				# Classes	#-Children			
BERKELEY, CA (Urban)	$16,000	9 mo.	4	5	121	2-4yr.	Clinical Social Worker (Private Practitioner)	60% Black 17% White 13% Hispanic
LIVE OAK, FL (Rural)	$14,300	12 mo.	6 (4)*	6 (4)*	104 (68)*	2-4yr.	6 Consultants- 1 Psychologists 1 Counselor 2 Coord.of Chld. Svc., 2 MH Technicians	56% Black 44% White
NEW ALBANY, IN (Urban/Rural)	$19,800	12 mo.	2	12	192	2-5yr.	10 Consultants- Psychologists	76% White 24% Black
NEW ORLEANS, LA (Urban)	$25,000	10 mo.	4	14	228	2-5yr.	6 Consultants Psychiatrists, Social Workers, Teachers	95% Black 5% White
BRIDGETON, NJ (Urban/Rural)	$25,000	12 mo.	11	15	378*	2-5yr.	3 Consultants 2 Psychologists 1 Social Worker	67% Black 25% White 8% Hispanic
INDIANA, PA (Urban/Rural)	$15,400	8 mo.	4	8	125	2-5yr.	2 Consultants-Cl. Psychologists Ed. Psychologist	98% White 2% Black 75% White
SPANISH FORK, UT (Rural)	$15,400	9 mo.	3	5	80	4 yrs.	6 Consultants 5 Psychologists 1 Cl.Social Wkr.	15% Hispanic 10% Nat. Am.
TACOMA, WA (Urban)	$27,000	10 mo.	10	14	275	4 yrs.	3 Consultants- Psychologists	48% White 38% Black 10% Nat. Am. 4% Hispanic

*Although there are currently 6 centers, Live Oak received no additional funds to serve its two nearest centers.

Table 3.5
CFMH Experimental Sites - Mental Health Worker Model

Site	Amount of Grant	Operation Time	Program Size			Age Group	MHW's Educ. Training	Ethnic Composition
			#-Centers	#-Classes	#-Children			
TROY, AL (Rural)	$26,000	9 mo.	6	15	291	2-5yrs.	(1)AA.,Education (2)College Course work in Business	88% Black 12% White
HOLYOKE/ CHICOPEE, MA (Urban/Rural)	$14,500	9 mo.	2	5	136	2-5yrs.	M.Ed. in Guidance & Counseling	73% White 23% Hispanic 4% Black
APPLETON CITY, MO (Rural)	$22,000	9 mo.	9	9	138	4 yrs.	Diploma + College Coursework	87% White 10% Black 3% Hispanic
RENO, NV (Urban/Rural)	$16,000	9 mo.	1	3	120	2-5yrs.	BA, Social Work	58% White 35% Black 5% Hispanic 2% Nat.Am.
GEORGETOWN, TX (Rural)	$19,800	9 mo.	4	9	170	2-5yrs.	Diploma + 24 hrs. Head Start Training	42% Hispanic 40% Black 18% White
LAREDO, TX (Rural)	$19,800	12 mo.	1	5	145	2-5yrs.	BA Child Development	85% Hispanic 12% White

Table 3.6
CFMH Control Sites - Community Resource Model

Site	Amount of Grant	Matched With	Operation Time	Program Size			Age Grp. Served	Ethnic Composition
				#-Centers	#-Classes	#-Children		
DECATUR, GA (Urban)	$1,000	LIVE OAK, FL.	12 mo.	1	5	86	2-5yrs.	90% Black 7% White 3% Asian
GRAND RAPIDS, MI (Urban/Rural)	$2,000	BRIDGETON, NJ	12 mo.	11	21	355	2-5yrs.	61% White 27% Black 7% Hispanic 2% Nat. Am. 1% Asian
MONROE, MI (Rural/Urban)	$1,000	INDIANA, PA	12 mo.	3	6	99	3-5yrs.	88% White 7% Hispanic 4% Black 1% Nat. Am.
CHESTER, PA (Urban)	$1,800	TACOMA, WA	12 mo.	23	25	270	2-5yrs.	75% Balck 15% White 10% Hispanic
RAPID CITY, SD (Rural)	$1,000	SPANISH FORK, UT	9 mo.	4	4	70	4 yrs.	47% Nat. Am. 38% White 6% Hispanic 6% Black 3% Asian
GALVESTON, TX (Urban)	$1,800	NEW ORLEANS LA	12 mo.	3	12	315	2-5yrs.	65% Black 19% Hispanic 16% White
LACEY, WA (Rural)	$1,500	NEW ALBANY, IN	8 mo.	4 ctrs. 4 home-based	4	180	-5 yrs.	80% White 11% Nat. Am. 6% Hispanic 2% Other 1% Black

Table 3.7
CFMH Control Sites - Mental Health Worker Model

Site	Amount of Grant	Matched With	Operation Time	Program Size			Age Grp. Served	Ethnic Composition
				#-Centers	#-Classes	#-Children		
HUGHESVILLE, MD (Rural)	$2,000	TROY, AL	12 mo.	7 centers 2 home-based	17	300	2-5yrs.	90% Black 10% White
KIRKSVILLE, MO (Rural)	$1,500	APPLETON CITY, MO	12 mo.		3	128	2-5yrs.	98% White 2% Hispanic
LAS VEGAS, NM (Rural)	$1,500	LAREDO, TX	10 mo.		8	120	4 yrs.	90% Hispanic 10 White
DEWEY, OK (Rural)	$1,500	GEORGETOWN, TX	9 mo.		6	120	2-5yrs.	54% White 30% Black 13% Nat. Am. 3% Hispanic
FRANKLIN, PA (Rural)	$1,000	HOLYOKE/ CHICOPEE, MA	12 mo.		4	60	2-5yrs.	88% White 12% Black
HILLSBORO, TX (Rural)	$1,000	RENO, NV	12 mo.	----------NO INFORMATION AVAILABLE----------				

Data Management and Control Procedures

When completed interview schedules were returned to contractor's offices, the session staff person responsible for control subjected the protocols to additional quality control reviews in order to:

1. Check for errors in recording, labeling of groups, etc.,

2. Resolve with field staff any questionable or unclear information prior to coding,

3. Identify any follow-up needed, and,

4. Make final status determinations on items and/or entire data protocols after follow-up has been attempted.

After reviews were completed, the data processing logs contained in each site file were logged to indicate which items had been cleared for coding and entry into the data base, which required additional follow-up, and which were deleted altogether for a particular program or respondent if all reasonable channels had been exhausted without success.

Training for Field Work. Because the staff who would serve as site visitors were intimately involved in evaluation planning and instrument development, only one day of training was considered necessary. The training included brief orientations by the staff responsible for the development of specific source documents, procedures for administering and recording interviews, as well as details of carrying out the various data collection and administrative tasks which are required by the site visit procedures outlined.

Site Visit Procedures. Since the field operations manual gives the details of the on-site data collection procedures, only a summary is provided here. The procedures required that the site visits open with an orientation meeting attended by the Site Visitor, Head Start staff, parents, and policy council members. The orientation meeting served a dual function, affording an opportunity for the evaluation staff member to learn about the program first-hand and for the Head Start representatives to learn about the purposes and methodology of the evaluation.

Although some flexibility in schedules was necessary, in most instances, immediately following the orientation, the field staff person reviewed the documents and records requested in advance. After a preliminary review of the information, interviews were held with staff and parents. Overall, site visits lasted for approximately two days at experimental sites and 1 to 1 1/2 days at control sites. Time was set aside in all cases to complete record reviews and to hold wrap-up sessions with staff after the last interview. Samples of the typical schedules for CR, MHW, and control sites are

shown in Table 3.8.

On-Site Quality Control. Time was allowed at the end of each interview at the end of each day for field staff to check their notes and completed interview protocols for clarity, completeness, and internal consistency among responses. Other aspects of quality control are considered.

Administrative Procedures. A separate report was required on each meeting, interview, or other contact at a site. The reports described participants, their reactions, and the Site Visitor's own appraisal of the interaction. At the close of the site visit, the staff person completed an additional summary report noting the physical setting and atmosphere of the program, the general level of cooperation or resistance encountered, and her/his impression of program strengths and weaknesses.

Table 3.8
Sample Site Visit Schedules

COMMUNITY RESOURCE (CR) SITES

Day 1		Day 2	
9:00- 9:30	Greetings/Introduction	9:00-10:00	Interview MH Coordinator
9:30-11.00	Orientation	10:00-10:30	Note check/planning
11:00-12:30	Record review	10:30-11:30	Interview Parent
12:30- 1:30	Lunch	11:30-12:30	Note Check record/review
1:30- 2:30	Interveiw HS Director	12:30- 1:30	Lunch
2:30- 3:00	Note check/planning	1:30- 2:30	Interview teacher
3:00- 4:00	Interview MH Consultant team leader	2:30- 3:00	Note check/planning
4:00- 4:30	Note check	3:00- 4:00	Wrap-up
4:30- 5:00	Daily log & notes		

MENTAL HEALTH WORKER (MHW) SITES

Day 1		Day 2	
9:00- 9:30	Introduction	9:00-10:00	Coordinator
9:30-11:00	Orientation	10:00-10:30	Note check/planning
11:00-12:00	Record review	10:30-11:30	Interview Parent
12:30- 1:30	Lunch	11:30-12:30	Note check/planning/ record review
1:30- 2:30	Interview HS Director	12:30- 1:00	Lunch
2:30- 3:00	Note check/planning	1:30- 2:30	Interview teachers
3:00- 4:00	Interview MHW	2:30- 3:00	Note check/planning
4:00- 4:30	Note check/planning	3:00- 4:00	Wrap-up
4:30- 5:30	Interveiw MH Supervisor		
5:30- 6:00	Daily log & notes		

CONTROL SITES

8:30- 9:00	Greetings
9:00-10:00	Orientation
10:00-11:00	Record review
11:00-12:00	Interview HS Director
12:00- 1:00	Lunch
1:00- 2:00	Interview MH Coordinator
2:00- 2:15	Note check/planning
2:15- 3:15	Interview teacher
3:15- 3:30	Note check/planning
3:30- 4:30	Interview PARENT
4:30- 5:30	Wrap-up

CHAPTER IV

SUMMARY OF PILOT STUDY OF PROCESS EVALUATION

The summary of the pilot study conducted in the Spring, 1979, as stated in the Phase I report, includes the results of the psychometric analysis of the center profiles. The results of the psychometric analysis of the process instruments provides a critique of the data collection procedures pre-tested in the pilot study and outlines the nature of the modifications and revisions that were made in instruments for the Phase II full scale process evaluation. The comparative analysis of the center profiles of the 9 experimental and 5 control sites visited in the pilot study is designed to provide a synopsis of preliminary trends relative to program variability, the extent to which the programs in general conform to CFMH guidelines and a primary prevention model, experimental and control group differences, and, overall effectiveness of the CFMH Projects. This synopsis will be categorized into the six categories utilized in the 14 center profiles. This descriptive analysis minimized systematic attempts to quantify the pilot data.

Synopsis of Site-Visit and Instrument Revisions

Following the site-visits, the Urban Institute for Human Services, Inc. field staff, who had participated in the pilot study of the process phase of the evaluation, prepared written critiques of the overall site-visits and, in particular, the process instruments, their adequacy and appropriateness. After having been reviewed by staff, their internal memos served as the basis for a half-day staff meeting to discuss the issues raised by the memos and make recommendations for appropriate revisions. The comments focused on a broad range of issues including the appropriateness of the site-visit schedules, attitudes toward the evaluation by Head Start staff, the comprehensiveness and technical adequacy of process instruments, the identification of the "best sources" for information about specific activities or information, the nature and adequacy of record-keeping procedures, the length of time required for conducting each interview schedule, etc.

Although the staff feedback was provided for each instrument included in the battery of process instruments, the discussion that follows summarizes the major issues or problems that were identified in the pilot study and which guided the revisions of the instruments and data collection procedures.

According to the field staff in the pilot study of the process phase, the Head Start staff and parents were extremely cooperative and supportive given that there had been only a few weeks lead time prior to the site-visits and, in some cases, the CFMH site-visits followed closely

behind an in-depth SAVI visit by the regional office of ACYF. In particular, the staffs of the local Head Start program were quite helpful in arranging the site-visit schedules, obtaining requested documents, data and records, and, sharing their perceptions of mental health activities with unusual candor. Also, the field staff reported that the program participants were comfortable with the evaluation and were quite knowledgeable about the purpose of the evaluation, the phases of the evaluation and its methods. Thus, the initial orientation meeting which was scheduled in order to discuss the role, nature, and, process of the three year evaluation was generally shortened due to the familiarity of the Head Start staff with the evaluation, and the Evaluation Contractor. Quite probably, the overall familiarity with the evaluation and the minimal resistance was due to the prior communications and presentations occurring at the previous conferences conducted by the training and technical assistance providers. The most consistent concern raised by the experimental program was the need to be informed as to the type and specificity of the records that should be maintained.

In contrast to the knowledge and familiarity with the evaluation by the participants at the experimental projects, the personnel at the control sites had very limited information about CFMH programs or the evaluation. There were particular concerns about the expectations of them as control sites, guidelines as to how to spend the monies allocated to them, and the nature of records that should be maintained.

The field staff concluded, in reference to the process instruments and data collection procedures, that the battery of instruments and other data collected during the pilot site visits was comprehensive in assessing the substance and the range of activities of the CFMH Projects. This judgement by the field staff was consistent with the widespread reactions of the respondents in the Head Start programs as to the broad and thorough coverage of the evaluation.

However, the instruments designed for the control programs failed to provide a mechanism for obtaining information directly from the Mental Health Providers. Though they worked with programs only on a consultant basis, these providers seemed to be the most knowledgeable about the mental health services. A common finding by the field staff was that the Mental Health Coordinator, the principal source of information about the mental health component in the control site, often was only peripherally involved with and informed about the mental health services and activities. At times, the Mental Health Coordinator merely served as a contact person and record-keeper rather than a coordinator or administrator, largely due to limited time assigned to mental health activities, as a result of other major roles or responsibilities within Head Start, and their limited mental health training and expertise. Also, several Head Start Directors suggested that since other Head Start staff, in addition to teachers and teacher aides, participated in mental health activities such as consultation and education, there should be some provision for their inclusion in evaluating the appropriateness and effectiveness of these services.

However, despite the overall comprehensiveness of the coverage of the interview schedules, the field staff identified items or content areas in which the respondents gave superficial, excessively global, or undifferentiated answers to the questions. At times, the respondents provided answers that were sufficiently general that the activities or services could not be determined as to whether it was primary, secondary or a tertiary level of intervention. For instance, it was frequently difficult to differentiate a "problem orientation" of mental health consultation and education that was related to normal developmental crises from a focus on an "identified problem child." The former emphasis would represent a primary prevention effort, while the latter focus would be more akin to a secondary prevention approach. Similarly, when the field staff requested information about the major objectives of the program; at times, the Mental Health Providers, particularly Mental Health Workers, would stop after the production of one or two broad objectives or merely repeat the CFMH guidelines. As a solution to the problem of the respondents' tendency to provide global, superficial responses, it was recommended that some questions would have to be redrafted to insure greater specificity and field staff need to be instructed as to the level of detail desired for answers or the extent of probing permissable in order to clarify or explain answers satisfactorily. Also, another recommendation to provide more useful information about goals and objectives was to have respondents rank the goals.

Another technical limitation in the design of the initial instruments that was identified in the pilot study was the difficulty for the respondents to make precise estimates of items requiring information about the units of services, number of participants, topics, etc. Also, the Head Start Directors experienced difficulty when requested to estimate the amount or percentage of the budget allocated to mental health without easy access to program records.

As noted previously, data from the pilot tests were used primarily to revise instruments and to determine the best sources of information for each of the areas covered in staff interviews. The key revisions made on the basis of pilot findings were as follows:

1. In accordance with the data collection strategy in Phase II and Phase III of the process evaluation, fall and spring versions of the instruments were developed. Generally, the fall versions focus on plans, goals and objectives in addition to the distribution of services and activities. The spring versions focus on actual services and activities, problems and their solutions, strengths and weaknesses of the providers' role and activities related to the mental health performance standards and to rate the effectiveness of the mental health component.

3. An instrument was developed for non-teaching Head Start staff such as service coordinators, nutritionist, etc.

in the experimental and control groups to determine the impact of the mental health activities on them.

4. Interview questions or items which require on-the-spot estimation of levels of services, time allocated to various activities, number of recipients or participants were deleted and that data will be obtained through the record-keeping system that ACYF will institute in local programs to insure more accurate data.

5. The predominance of questions and items in interviews were changed from open-ended to close-ended to facilitate data processing, and to insure conformity with OMB guidelines.

Finally, the RFP guidance questions utilized in developing the process measures are in Table 1 in the appendix. A brief description of the major classes of variables in the process evaluation are outlined in Table 2, and are matched with the guidance questions in Table 3.

Descriptive Summary of Center Profiles

Demographic Characteristics of the Community and Head Start Setting

Demographic data based on the 1970 census, program narratives and proposals demonstrate the considerable diversity within both the experimental and control groups. The individual center profiles reflect the wide variability among programs in terms of urbanization, the size of the geographical area which the Head Start program serves, the ethnic distribution of the community, the availability of social services and a variety of socio-economic variables such as income level, years of education, unemployment rates, percentage of families below the poverty level. For instance, some of the Head Start programs in the sample are located in rural, physically isolated settings in which they are responsible for providing services to several counties. In contrast, other programs are located in urban, highly industrialized areas, in which the population density is high, with the major urban problems such as poverty and unemployment. Similarly, the racial composition of the community which the Head Start center serves may range from predominantly black to an all white population, or the Head Start programs may be composed primarily of a Spanish-speaking migrant population.

History and Start-Up of CFMH Projects

In planning and development of the CFMH proposal submitted to ACYF, the Head Start centers used their already existing relationship with a collaborating mental health agency or mental health professional to provide their knowledge and expertise in primary prevention. The most typical agencies involved in the process of proposal development

were community mental health centers, family services agencies or child guidance centers. The most common needs identified among the Head Start programs as the rationale for requesting funding for the CFMH proposal were the importance of building on already existing priorities in primary prevention in mental health, limited availability of mental health professionals, lack of monies for primary prevention, in contrast to secondary prevention, physical isolation and distance causing difficulties in obtaining mental health professionals, particularly in rural areas. Generally, the Head Start Parent Policy Council either participated in the planning process or gave final approval to the proposal.

Although the control sites were not awarded a CFMH grant, they indicated a similar process in the planning and development of the proposal and their rationale for requesting CFMH monies were consistent with the program needs identified above. Prior to the communications with the evaluation contractor preparatory to site visits, the 5 control sites visited had minimal contact with ACYF. Further, although most of these control sites received the funds provided for participating as control centers in 1977-78, they were not informed of guidelines for spending the monies, and therefore either did not spend it in the first year or spent only a portion.

Also, the center profiles provide data pertaining to the effective implementation of the CFMH Projects, particularly during the "start-up" phase. Overall, the CFMH programs reported having a few major start-up problems during the initial program year, 1977-78. Only two programs of the nine CFMH Projects reported having major start-up difficulties. For instance, one of the Head Start programs had problems in its first few months with state and local mental health agencies about whether Head Start could deliver mental health services without their permission, supervision and without a license. However, following several meetings between representatives and the state and local mental health agencies, the issues were resolved satisfactorily. Another program experienced start-up difficulties due to problems in communication with ACYF, causing it to receive the CFMH funds late and, therefore, the CFMH Project initiated its program operations in October, 1977 rather than September, 1977. Although not reported as major difficulties, the various CFMH Projects listed a variety of other problems that affected program implementation such as staff turnover, lack of clarification of the role of the CFMH program, initial staff reservations about the use of a paraprofessional as Mental Health Provider, inadequate parent participation, etc. Nevertheless, most of the CFMH programs were able to overcome their problems and to implement the programs effectively.

Project Structure, Administration and Coordination

As stated in the original CFMH guidelines, the project funded conformed to either the Mental Health Worker model or the Community Mental Health Resource approach. The Mental Health Worker model, particularly appropriate to rural areas or other areas lacking mental health

facilities and resources, involves a paraprofessional serving as the major provider of mental health services, under the supervision of a mental health agency which is responsible for the delivery of mental health services to the Head Start program. According to the pilot data on the nine experimental centers visited in the Spring, four centers were implemented according to the Mental Health Worker model and five programs conformed to the Community Resource model. All of the programs that utilized the Mental Health Workers' approach generally had one mental health worker as the primary delivery of services, except for one program which employed two Mental Health Workers with their CFMH Projects. Although the primary role of the Mental Health Supervisor in the Mental Health Worker model was to provide supervision of the paraprofessional, frequently they also participated in some of the CFMH Project activities such as in-service training for staff, workshop for parents, etc.

According to the pilot data, the Head Start Directors generally have overall responsibility for the CFMH program, particularly related to grants management, fiscal and administrative matters. Generally, the day-to-day operations of the project are handled by the primary Mental Health Provider, who works in conjunction with the Head Start Mental Health Coordinator to insure coordination between the CFMH Project, the mental health component and the total Head Start program. However, in some cases, the Mental Health Supervisor not only provides technical supervision of the clinical activities of the Mental Health Workers, but also assumes some administrative responsibility for monitoring program activities. Also, in those Head Start programs utilizing the Community Resource model, frequently, a staff member is designated as the collaborating mental health agency to assume responsibility for staff assignments, program development, monitoring and evaluating the day-to-day performance of the CFMH Providers. Finally, the principal mechanisms for coordinators of the various components, case conferences to discuss plans for children, and written reports or plans.

Major Goals, Objectives and Activities

The major goals and objectives articulated by the experimental projects were consistent with the CFMH guidelines and the goals of primary prevention in mental health. Although the specific goals and objectivities of the CFMH Project differed from program to program, they generally were focused on developing positive mental health, strengths or competencies rather than "problem children," illness, or psychopathology. Thus, the mental health activities, as stated, were designed to increase the staff and parents' awareness of social and emotional needs of children, identify impediments to healthy child development and provide skills and techniques for ensuring the child's development.

Despite the wide diversity in the extent, type and style of mental health services provided between the CFMH programs, in general, the services were in accordance with CFMH guidelines. That is, though

differing in service emphasis, all of the CFMH programs reported provide the following services:

1. Orientation to staff and parents
2. Classroom observations
3. Consultation to staff
4. In-Service training to staff
5. Parent counseling including crisis counseling
6. Parent education

Consistent with the primary prevention approach, the bulk of the services delivered were indirect services, primarily consultation and education activities focused on staff and parents. There were few direct services to children such as formal diagnostic assessment or therapy. The limited direct services provided directly to children were the classroom observations and, in a few instances, developmental screening. However, the classroom observations were in accord with primary prevention, since their purpose was to provide data for the intervention with "caregivers" (i.e., teachers, parents), rather than for the purpose of direct intervention with children. The developmental screening which was generally conducted on all children, though more congruent with the secondary prevention approach of early identification and intervention, was provided only to a limited extent, relative to other services by the CFMH Project. There were two program exceptions to the trend of providing few direct services to children. One of the programs had an extensive child aide's program which involved aides working with children in the classrooms experiencing emotional or social difficulties, based on a teacher rating scale used to screen all children. A second program reported having provided one-to-one therapy with identified children experiencing difficulties or through the use of group educational activities.

However, despite the pervasive focus on indirect mental health services, at times, there was a classification problem relative to the level of preventive intervention involved. For instance, frequently in describing services such as case consultation to Head Start Staff or parent workshops, the Providers spontaneously reported discussions of problem children related to developing observational skills for detecting emotional difficulties in children or the identification of appropriate child management techniques. Yet, in the absence of more data about the severity of the child's problem or the goals and objectives of the Providers, it is difficult to determine whether the focus is primary, secondary or tertiary. It is conceivable that the focus on "problem children" may refer to normal developmental difficulties in pre-schoolers, childhood problems reflective of a more "at risk" status or severe emotional or psychological impairment (i.e., autism).

In comparison to the CFMH Projects, the mental health services at the control sites differed in terms of the extent, range and type of services delivered. That is, the center profiles indicated that the experimental projects show a substantially greater number of hours in

service delivery. Also, there is a greater range in the number of different services provided by the CFMH Projects relative to the mental health components of the control sites. Finally, the control sites' pattern of service delivery showed a trend toward greater emphasis on secondary and tertiary prevention, and to a lesser extent, primary prevention. As noted previously, the emphasis in the CFMH programs was the reverse.

Support System

The center profiles reveal a wide range in the availability of internal and external resources and support to assist the experimental and control sites. The most common source of internal support reported by the CFMH program, particularly the Community Worker model, was the Mental Health Supervisor, though technically a member of the CFMH team. In reference to external resources of support, several of the CFMH programs stated that the mental health and other community agencies that could be enlisted to support the preventive thrust of the CFMH Project. The agencies that were identified as viable resources were the community mental health centers, child guidance centers, family services agencies, institutions serving handicapped children, protective custody agencies and other social services agencies. A few of the experimental and control centers praised their affiliation with local colleges and universities as valuable resources for referrals or the source of trainees. However, despite the presence of a viable network of mental health resources in some communities, the more predominant responses were complaints of the limited resources available, particularly those Head Start centers in rural, physically isolated areas. Other centers complained that the available mental health resources were too traditional, adult oriented, and limited in expertise or services for pre-school children.

Nevertheless, most of the programs reported that the CFMH Project had increased the network of services available to assist the Head Start program.

Evaluation of the CFMH Project

The center profiles indicate that, in general, the Head Start program had not instituted internal, formal mechanism for either evaluating the performance of the CFMH staff or assessing the overall impact of the programs on staff, families or children. The most common method of obtaining feedback on the effectiveness of the CFMH program is informally through conversations with or reports by parents and staff. There are a few programs that have some formalized procedures for program evaluation, such as evaluation surveys and questionnaires developed by the CFMH Provider and/or program coordinators or administrators to determine the effectiveness of specific services (i.e., teacher training). In one program, however, the Head Start Director implemented the Program Evaluation and Review Technique (PERT) as a more formalized mechanism. With those centers that do employ systematic procedures for program evaluation, whether formal or informal, the person typically responsible for

evaluating the CFMH Project is the Head Start Director. In a few cases, the CFMH Coordinator or Mental Health Supervisor is responsible for the evaluation and in other centers, such as those adopting the Community Resource model, a staff member at the collaborating agency may conduct the evaluation. It is not clear in the latter case involving the Community Resource model whether the evaluative information is communicated to the Head Start program, or, if so, in what form.

Nevertheless, the responses and evaluations of the individual programs were overwhelmingly positive or favorable. Based on the rating scale in the Head Start staff's interviews, the programs were rated as "very effective" and "effective." The mental health services were viewed as appropriate, prompt and effective. Informal and unsolicited comments from Head Start staff and parents concurred in those assessments. However, there was considerable diversity to the specific program activities identified as most effective from one program to another. Similarly, in the program areas singled out for improvement, there were a range of areas singled out. They included the need for greater parent involvement, more communication and coordination with the collaborating mental health agency, greater emphasis on growth orientation than problem orientation, greater program stability as a result of reduced staff turnover and role changes, etc.